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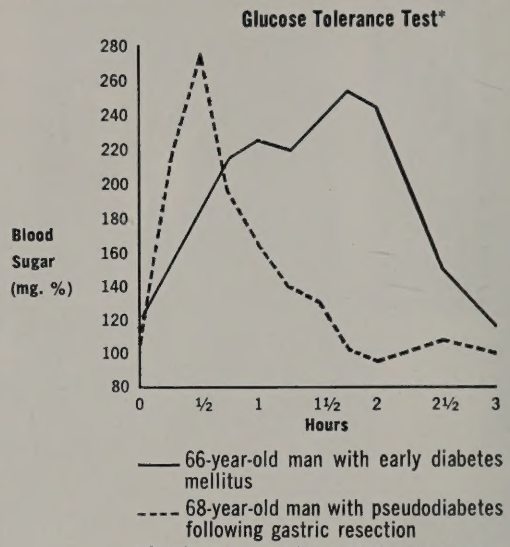

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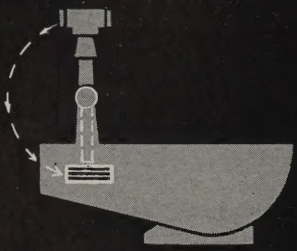

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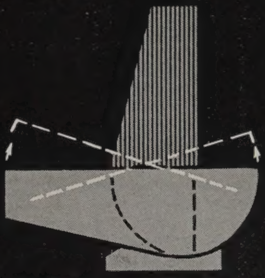

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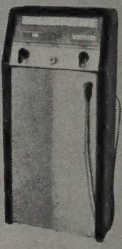

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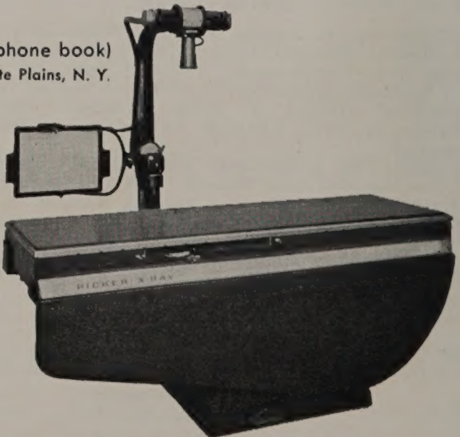

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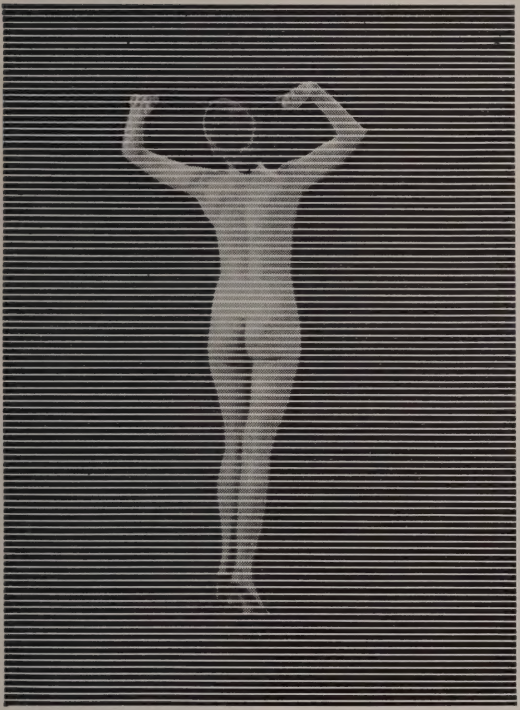

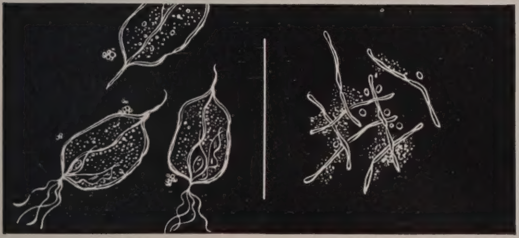

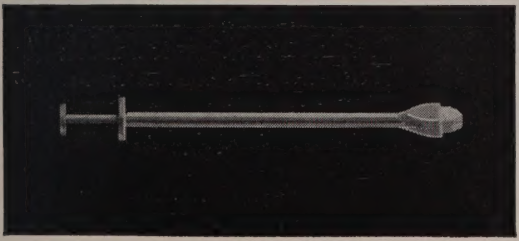

Vaginal discharge is one of the most common and most troublesome complaints met in practice. Trichomoniasis and monilial vaginitis, by far the most common causes of leukorrhea, are often the most difficult to control. Unless the normal acid secretions are restored and the protective Döderlein bacilli return, the infection usually persists.

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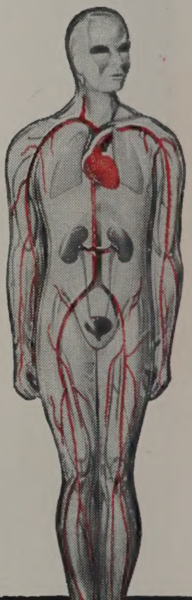
Investigator after investigator reports

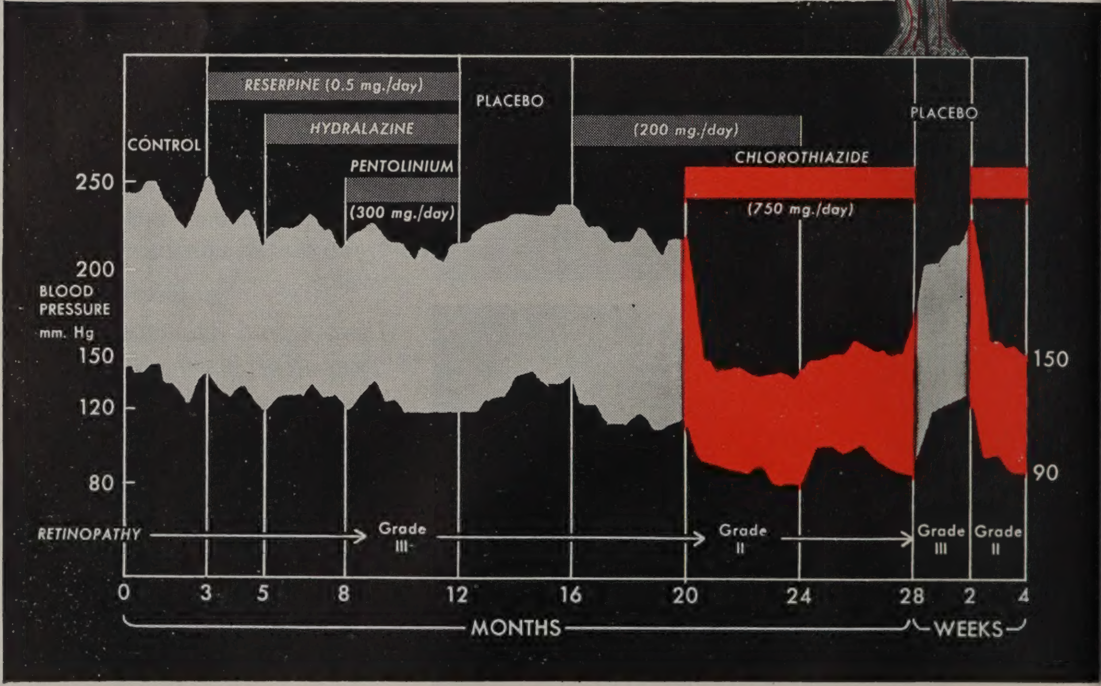
Wilkins, R. W.: New England J. Med. **257:1026**, Nov. 21, 1957.

"Chlorothiazide added to other antihypertensive drugs reduced the blood pressure in 19 of 23 hypertensive patients." "All of 11 hypertension subjects in whom splanchnicectomy had been performed had a striking blood pressure response to oral administration of chlorothiazide." ". . . it is not hypotensive in normotensive patients with congestive heart failure, in whom it is markedly diuretic; it is hypotensive in both compensated and decompensated hypertensive patients (in the former without congestive heart failure, it is not markedly diuretic, whereas in the latter in congestive heart failure, it is markedly diuretic). . . ."

Freis, E. D., Wanko, A., Wilson, I. H. and Parrish, A. E.: J.A.M.A. **166:137**, Jan. 11, 1958.

"Chlorothiazide (maintenance dose, 0.5 Gm. twice daily) added to the regimen of 73 ambulatory hypertensive patients who were receiving other antihypertensive drugs as well caused an additional reduction [16%] of blood pressure." "The advantages of chlorothiazide were (1) significant antihypertensive effect in a high percentage of patients, particularly when combined with other agents, (2) absence of significant side effects or toxicity in the dosages used, (3) absence of tolerance (at least thus far), and (4) effectiveness with simple 'rule of thumb' oral dosage schedules."





In "Chlorothiazide: A New Type of Drug for the Treatment of Arterial Hypertension," Hollander, W. and Wilkins, R. W.: Boston Med. Quart. 8: 1, September, 1957.

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The Physician's Bookshelf

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Handbook of Medical Treatment, by Milton J. Chatton, M. D., Sheldon Margen, M. D., and Henry Brainerd. ($3.00, 5th edition, *Lange Medical Publications, Los Altos, California.* This still continues to be the best handbook on medical treatment to meet the needs of the medical student and practitioner, either in his white jacket or in his bag. Of course, it had its origin and still has its roots in the medical school of the University of California, in San Francisco.

Surgery in World War II: Orthopedic Surgery in the Mediterranean Theater of Operations: Editor-in-Chief, Colonel J. B. Coates, Jr., Editor for Orthopedic Surgery, Mather Cleveland, M. D. ($4.00, *Office of the Surgeon General, Department of the Army, Washington 25, D. C.)* This volume will prove of great interest to all medical officers who served in the Army whether they have returned to civil life or not. It is a record of the outstanding services which these physicians rendered during the conflict. It will serve also as a source of information to the medical student who now or will follow them into the medical services of the Armed Forces.

Healthful School Living, by Charles C. Wilson, M. D. ($5.00, *National Education Association, American Medical Association, 535 N. Dearborn St., Chicago 10, Illinois.)* A report of the Joint Committee of the two societies with the cooperation of many contributors and consultants.

Lymphatics Lymph and Lymphoid Tissue, by J. M. Yoffey and F. C. Courtice. ($10.00, *Harvard University Press, Cambridge 38, Mass.)* This edition is essentially a new book and is a most complete review of the subject. Researchers in mediscine and immunology will need a copy for ready reference.

Experimental Psychopathology, by Paul Hoch, M. D. and Joseph Zubin, Ph.D. ($6.50, *Grune & Stratton, Inc., New York 16, New York.)* Since the days of Kraepelin, Bleuler, Jaspers, et al., psychopathology has progressed from description to experiment. This means that sooner or later the subject will get on a scientific basis. This volume brings us up-to-date on these early attempts to do so.

Six Children, by Estelle J. Foote, M. D. ($5.50, *Charles C. Thomas Publisher, Springfield, Illinois.)* This book is based upon the complete study by examination of the author of over 3600 children. It offers much fresh material for diagnosis and advice. Emphasis is placed upon full family history, personal characteristics as seen by parents; the child's progress in school and his characteristics as seen by the teacher; accurate determination of his real progress in each of his school's subjects; psychometric tests; and finally physical examination and interview.

Mental Health in Childhood, by Charles L. C. Burns, M. D. ($2.75, *Fides Publishers Association, Chicago 19, Illinois.)* A well known British psychiatrist of Birmingham Child Guidance Service writes as a parent as well as an expert. He outlines in non-technical terms the development of the child and the ways difficulties can arise.

Treatment of Burns, by Curtis P. Artz, M. D. and Eric Reiss, M. D. ($7.50, *W. B. Saunders, Philadelphia 5, Pa.)* This is designed as a guide for the treatment of burns in accordance with present-day knowledge. An unique feature is the emphasis upon the art as well as the science of medicine.

Alcoholism: A Treatment Guide for General Practitioners, by Donald W. Hewitt, M. D. ($3.00, *Lea & Febiger, Philadelphia 6, Pa.)* This is believed to be the first book of its kind intended primarily for the general practitioner to help him meet the widespread need for specific management, treatment and follow-up therapy of alcoholism as it is encountered on all social levels. The work is based on the successful results obtained from treating an average of 100 alcoholics a month in the largest alcholoic rehabilitation center of its kind in the western United States. Dr. Hewitt establishes a new understanding and sympathy on the part of the physician, and stresses the vital need to secure the confidence and cooperation of his alcoholic patient's family and friends. The necessary steps which must be taken —and how to take them—are outlined clearly. Antabuse, Thorazine, Sparine, and other currently accepted drugs are included in the sections on therapy.

Alcoholism, by Harold E. Himwich, A Symposium of AAAS: ($5.75, Publication No. 47. *American Association for the Advancement of Science, 1515 Massachusetts Ave., N.W., Washington 5, D. C.)* Deals with psychiatric, physiologic social and interpersonal aspects of the problem leaving the reader to draw his own conclu-

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Riseman, J. E. F., Altman, G. E., and Koretsky, S.:
Nitroglycerin and Other Nitrites in the Treatment of
Angina Pectoris, Circulation (Jan.) 1958.

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sion as to the moral aspects. Our own Chauncey D. Leake wrote the introduction setting the stage historically, and Fred Hitchcock helped arrange the symposium. The multi-disciplinary facts of AAAS facilitates this sort of a presentation.

The Legacy of Doctor Wiley, by Maurice Natenberg with an introduction by Jonathan Forman, M. D. ($3.00, *Regent House, Chicago 40, Illinois.)* The author of this book has done a great service in recalling to the younger generation the life and works of Harvey W. Wiley, M. D. The thesis is that in these days when nearly a thousand chemicals are added to our food the effects of which we are for the most part ignorant, and that the original Pure Food and Drug Act would be adequate if amended and properly enforced. The second half of the book deals with the many dangers we are faced with through evasion and hamstringing combined.

Health Year Book: 1956, by Oliver E. Byrd, M. D. ($5.00, *Stanford University Press, Stanford, Calif.)* The author read 2000 articles in some 300 medical journals and selected 254 articles for review. Consequently this book offers a good cross section of programs in health matters.

Integrated Anatomy and Physiology, by Carl C. Francis, M. D. and Gordon L. Farrell, M. D. ($5.85, 3rd ed., *C. V. Mosby, St. Louis 3, Mo.)* Written in the belief that structure cannot be understood without a knowledge of function and it is impossible to discuss function without a basis of structure. The result is an excellent text for the student who requires a basic knowledge of the human body.

The World Health Organization, A Study in Decentralized International Administration, by Robert Berkov, ($4.50, *Gregory Lounz, Distributing Agent, 11 E. 45th St., New York 17, N. Y.)* This study analyzes the structure of WHO, assesses the effects of its policy of decentralization and draws general conclusions as to the success decentralization might play in the successful administration of international programs.

Rypin's Medical Licensure Examinations, by Walter L. Bierring, M. D. ($10.00, 8th edition, *J. B. Lippincott Co., Philadelphia 5, Pa.)* Contains topical summaries and a list of questions well designed to help anyone preparing for such an examination. Each section has been prepared by a recognized authority.

Calderwood's Orthopedic Nursing, by Carroll B. Larson, M. D. and Marjorie Gould, R. N. ($5.75, 4th ed. *C. V. Mosby Company, St. Louis 3, Missouri.)* Primarily this edition brings in new procedures of treatment which have evolved as a natural sequence of progress in orthopedic surgery. Secondly, the book presents improvements which have resulted from collected criticisms of the last edition which have been made in several areas. This edition will undoubtedly be as well accepted as the previous one.

Forest Doctor: The Story of Albert Schweitzer, by Wm. Cecil Northcutt. ($1.50, *Roy Publishers, New York 21, N. Y.)* Albert Schweitzer, the forest doctor of Lamdrene in French Equatorial Africa spent 40 years of his life in this forest hospital. What made him—musician, philosopher, theologian—leave Europe for Africa? The answer makes one of the most thrilling tales of our time.

A Manual of Pharmacology, by Torald Sollman, M. D. ($20.00, 8th ed., *W. B. Saunders Co., Philadelphia 5, Pa.)* For more than forty years this manual has been kept up to date by the distinguished pioneer in modern pharmacology at Western Reserve University. He has offered a critical summary of all significant contributions to the field. In spite of all efforts to keep the text within bounds it contains 1535 pages.

Biochemical Problems of Lipids, by G. Popjak and E. Le Breton. ($10.75, *Interscience Publishers, Inc., New York 1, N. Y.)* This is the proceedings of the second International Congress held at the University of Ghent, organized with the collaboration of the Zlaanse Chemische Vereniging of Belgium under the presidency of Professor R. Ruyssen.

Epilepsy: Grand Mal, Petit Mal, Convulsions, by Letitia Fairfield, M. D. ($4.75, *Philosophical Library, Inc., New York 16, N. Y.)* This is the first full-length British book to summarize for the public exactly what is known about the various forms of this disease, what treatments are available, what special problems are presented by epilepsy in children, and what employment the epileptic can expect to find for himself in the workaday world. The reading of this book will help epileptics to get their troubles in proper perspective and it makes a pretty good review for us physicians who are not constantly in touch with this problem.

Surgeons All, by Harvey Graham, M. D. with foreword by Oliver St. John Bogarty. ($10.00, *Philosophical Library, Inc., New York 16, N. Y.)* This story of a thousand and one surgeons was first published a few months before Hitler's invasion of Poland. Despite numerous and excellent reviews the book naturally did not achieve the wide sales that it deserved owing to the restrictions of the war. Since that time many important

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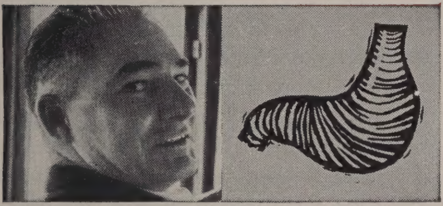
SR is a cardiac patient. His doctor put him on ATARAX because (+) it is an anti-arrhythmic and non-hypotensive tranquilizer.



Other tranquilizers added to PN's g. i. discomfort (he has ulcers). But now his doctor has him on ATARAX because (+) it lowers gastric secretion while it tranquilizes.

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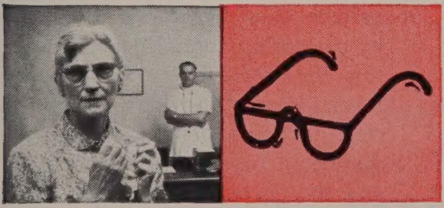

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discoveries have been made in surgery and the author has added a further section to the book bringing this fascinating story right up to date. It starts with the healing knife of a sharp flint and tells the story of Egypt, and old China, and India, how surgery grew up in Greece and Rome and then was lost for a while to be found again in the Middle Ages. The story is one of Man's constant struggle against death. It is a book that every physician should read. It is not only instructive but entertaining even to the lay reader.

Judaism and Psychiatry: Two Approaches to the Personal Problems and Needs of the Modern Man, by Simon Noveck. ($3.95, *Basic Books Publishing Company, New York 3, N. Y.)* Adding a new dimension to the understanding of the Jewish way of life and its relevance to the pressures of contemporary living, this book by 16 prominent psychoanalysts and rabbis is the first to point up the psychological soundness of Jewish teachings and the contributions that they can make to the resolution of personal problems.

Obesity: Its Cause, Classification and Care, by E. Philip Gelvin, M. D. and Thomas H. McGavack, M. D. ($3.50, *Harper and Brothers, New York 16, N. Y.)* This gives us from the benefits of the authors' 10 years' experience in a specialized obesity clinic a simple yet effective program which can readily be applied to office practice, incorporating all the new knowledge that we have in chemistry, in physiology. It offers no panacea or anything sensational or magical but it does give us an integrated program for the person who desires to control this disease.

Year Book of Endocrinology 1956-57 Series, by Gilbert S. Gordan, M. D. ($6.75, *Year Book Publishers, Chicago 11, Ill.)* Rapid moving advances in endocrine chemistry have virtually revolutionized previous concepts of the nature of hormones and therefore a book such as this of intelligently selected articles for review and comment by competent personnel is something that every physician, no matter what his interests in medicine, will do well to study.

Science Looks at Smoking, by Eric Northrup, with introduction by Dr. Harry F. M. Greene, Chairman, Department of Pathology, Yale University. ($3.00, *Coward - McCann, Inc., New York 16, N. Y.)* Among scientists there is always the one who is a stickler for the last bit of evidence to be all in before any conclusions be drawn, and there is the imaginative scientist who emphasizes the general trend of the evidence. This we find in discussion of all human poisons, cancer research, chemical additives to foods, influence to fertilizer in the soil upon plants, etc. Here a well-known science writer has made a serious effort to inquire into the effects of smoking and appraise the reports that have been so widely circulated. The book points out the faulty research methods and the preconceived attitudes that have made suspect some of the publicized conclusions on smoking as a cause of lung cancer and failure. Since there are two sides to this question this popular presentation of Dr. Greene's analysis of the situation is very much worth while for every doctor to read before he comments on this controversy to his patient.

Guerrilla Surgeon: The Adventures of a New Zealand Doctor in Yugoslavia, by Lindsay Rogers. ($3.95, *Doubleday and Company, Garden City, New York.)* Lindsay Rogers is a surgeon, a highly skilled and tenacious battler against suffering and death and this is the story of how he used his skills to aid the Yugoslav partisans in World War II. During the German occupation of the Balkans, Dr. Rogers, then a British army major, undertook a frighteningly difficult mission to set up centers for treating the partisan wounded in the wild mountainous countryside of Yugoslavia. The odds against success were staggering. The Germans hunted the doctors with fanatical skill, executed those who were caught alive. The Yugoslavs were poorly trained and badly equipped and at every turn Rogers was snared by Communistic red tape. It was an impossible job but he reports he did it.

Regulation and Mode of Action of Thyroid Harmones: A Ciba Foundation Symposium, by G. E. W. Wolstenholme, M. D. and E. C. P. Millar. ($8.50, *Little, Brown and Company, Boston 6, Mass.)* This is the 10th Colloquia on Endocrinology produced by these Symposia. During the last 15 years there has been an enormous activity in the field of thyroid investigation. This volume takes stock of the discoveries of this period by presenting formal papers by leading investigators the world over. These papers, and the informal discussions which follow them, serve as a clearing house of ideas on the latest concept of regulation of the thyroid gland on the one hand and the character and mode of its hormones on the other.

Brain Mechanisms and Drug Actions: A Symposium of the Houston Neurological Society, by William S. Fields. ($4.25, *Charles C. Thomas Publisher, Springfield, Ill.)* This is a timely subject because of the growing interest in it and this symposium gives us the present-day thinking on the subject which is now occupying the attention of internists, neurologists, psychiatrists and others interested in the manner tranquilizing drugs act on the nervous system.

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Social Security for Physicians . . .

Poll To Determine Opinions of OSMA Members To Be Conducted in October; Material Pro and Con on Subject To Be Carried in The Journal

AT THE 1958 Annual Meeting of the Ohio State Medical Association in Cincinnati, April 14-17, the House of Delegates adopted a resolution, calling for a poll of members on the question of whether or not physicians should be included in the Federal Social Security Program. It read as follows:

> **"WHEREAS, The inclusion of doctors of medicine in the Federal Social Security program is currently under consideration, and**
>
> **"WHEREAS, The Ohio State Medical Association and the American Medical Association are now on record as opposing the inclusion of physicians in the Social Security program, and**
>
> **"WHEREAS, A considerable number of physicians in Ohio have expressed a desire to be included in the Social Security program, and**
>
> **"WHEREAS, It is desirable to ascertain the current sentiment of all members of the Ohio State Medical Association on this question,**
>
> **"THEREFORE BE IT RESOLVED, That (1) the individual members of the Ohio State Medical Association be polled by the Association on the question as to whether they favor or oppose the inclusion of physicians in the Federal Social Security program, and (2) the results of this poll showing the number of votes in favor of and in opposition to such inclusion be made a matter of record and transmitted to the House of Delegates of the American Medical Association, and**
>
> **"BE IT FURTHER RESOLVED, That such poll be conducted prior to the 1958 interim session of the American Medical Association so that the results of such poll can be submitted to the House of Delegates of the American Medical Association at said meeting."**

The poll authorized by the House of Delegates will be conducted during the month of October.

Prior to that time, also by order of the House of Delegates, *The Journal* will present in each issue (July, August and September) selected material and comments, pro and con, on the subject of coverage of physicians under Social Security.

The first of the material which has been assembled appears in this article. Members who may have comments on this subject which they think would be of educational value to all members should send it to the Columbus Office where it will be reviewed and considered for publication.

Members should bear in mind that opinions expressed by the writers of the articles appearing in *The Journal* are solely the opinions of the authors and do not necessarily reflect the opinions of officials of the Ohio State Medical Association or staff members of *The Journal.*

Moreover, members should realize that some of the material being used was written several years ago. For that reason some of the figures may be out-dated. Nevertheless, the articles still are of value in this debate as they express basic opinions or present philosophical arguments on one side or the other.

* * *

Pro and Con Arguments

HERE are arguments, pro and con, on the question: Should the Old Age and Survivors Insurance provision of the Federal Social Security Act be amended to require the coverage of self-employed physicians?

The arguments appeared originally in the October, 1957, issue of *GP,* publication of the American Academy of General Practice, having been compiled by the Alabama Academy of General Practice after reviewing many articles, editorials and pamphlets on this subject. Referring to this the Alabama organization said: "The most pertinent arguments for and against social security for doctors as we see it are presented herewith. These arguments do not necessarily reflect the thinking of the author of this letter. They have been lifted in part or wholly from writings or statements of people who are considered experts on the subject. Every effort has been made to present these arguments in an unbiased manner."

Arguments For

The Philosophy of Social Security

A few words should be said about the philosophy of social security. On the heels of the

Arguments Against

Represents Creeping Socialism

Few would argue that the social security program arose from a real need in the early 1930's following

Arguments For (Cont'd)

depression in 1930, the "philosophy of federal concern for services and benefits traditionally discharged by states, communities, and individuals" began to develop. There was a growing conviction among many that federal unconcern for its citizens' problems is synonymous with national irresponsibility. Pressing needs created by economic crisis (e. g., the depression) cannot always be solved personally, regardless of the intention of the individual involved; there is a social and group character to the problem.

The quest for security and protection in old age or after death in an era of high costs, high taxes, declining earnings later in life, and general economic uncertainty is a legitimate one. Thus in 1935, the basic principle of using federal funds to advance the social security of all citizens won widespread popular support and has apparently become more popular with passing time.

President Eisenhower in his social security message of January, 1954, said that OASI developed in response to a need "arising from the complexities of our modern society." The system is not intended as a substitute for private savings, insurance plans and insurance protection. It is intended rather as a foundation upon which other forms of protection can be soundly built. Thus, the individual's own work, his planning and his thrift will bring him a higher standard of living upon his retirement, or his family a higher standard of living in the event of his death than would otherwise be the case. Hence the system both encourages thrift and helps to prevent destitution in our national life.

COMPULSORY COVERAGE OR NOTHING

Many doctors have expressed a desire for voluntary coverage under social security. This would seem to be out of the question because it is not actuarially sound and because Congress will not pass a bill giving this special privilege to self-employed doctors. Therefore, doctors either accept compulsory coverage or get nothing at all. Furthermore, it is unlikely that doctors will obtain a tax-deferment retirement program, as provided in the Jenkins-Keogh bill, until they are covered by compulsory social security.

DOCTORS STAND ALONE IN OPPOSITION

All other organizations of self-employed professional people have endorsed the principle of compulsory coverage. Lawyers, who should certainly have a better understanding of the laws of

(Continued on Page 870)

Arguments Against (Cont'd)

the depression and has served and will continue to serve a useful function. However, since its inception, there seems to have been a change in political thinking. What was originally set up as a plan to provide a minimum of protection for the poor is now being extended into all phases of our country's social and economic body.

Again, few would argue that the federal government has a vital role to play in solving the problems of its citizens. However, too much substitution of individual responsibility by social or federal responsibility leads to a compromise of our independence and to a deterioration of the moral fiber of the nation.

There is little or no difference in the philosophy of compulsory old age and survivors insurance and the philosophy of compulsory health insurance. Doctors cannot divorce one from the other and accept the so-called "bargain rates" of social security for themselves and loudly deny the so-called "bargain rates" of socialized medicine to their neighbor's children who are in need of medical care. The entire concept of social security has as one of its basic features the socialization of health services. This has been proved by the course of social security legislation followed in European countries. As recently as 1947, legislation was proposed in the Congress of the United States to effect a compulsory health insurance program in this country. This legislation was largely formulated by the Social Security Administration at that time. Disability benefits enacted by Congress earlier this year in HR 7225 bring the Social Security Administration closer to the regulation of medical care.

ORGANIZED MEDICINE FAVORS JENKINS-KEOGH BILLS

Most physicians favor voluntary social security coverage but recognize the fact that such legislation is extremely unlikely. In preference to compulsory coverage, organized medicine is giving its active support to the Jenkins-Keogh bills. These bills would amend the Federal Internal Revenue Code so that self-employed physicians and others would have the same tax deferment advantages on the amounts set aside for retirement as are now enjoyed by officers and employees of corporations and associations, and others. A recent congressional poll indicates that this legislation has a good chance of passage this session.

SOCIAL SECURITY IS NOT INSURANCE

The OASI program is not really an "insurance" program as it is called. This was ruled by the

(Continued on Page 870)

Arguments For (Cont'd)

the land than their medical colleagues, have accepted the program. Life insurance underwriters have not objected to OASI; they must therefore consider it preferable in some respects to private insurance.

PRIVATE INSURANCE COMPANIES CAN'T OFFER SAME BENEFITS

Private insurance companies can't administer a similar program at less expense. A doctor must pay $7,000 to $25,000 more than a dentist or lawyer pays for retirement and life insurance. The survivors of an individual covered by OASI stand to gain as much as $38,000, with a much more likely figure being $34,000, in the event of his death.

The pension for a dentist or lawyer approaching 65 and retirement may provide ridiculously high returns on investment. Using an extreme example, a man may obtain a pension for himself and his wife of $162.80 for a payment of only $189 in taxes over a 18-month period before retirement. There are special advantages for an individual who is entirely uninsurable or insurable only at high rates.

Arguments to the effect that private insurance companies offer programs comparable in cost and benefits to OASI do not consider the combined package representing the very considerable survivor protection and appreciable retirement program.

SOME DOCTORS STAND TO LOSE OASI CREDITS

Many self-employed doctors have some OASI credits as a result of military service, teaching, previous salaried positions, etc. If these self-employed doctors are to continue to be excluded, these credits will be lost.

OASI SOLVENCY MAY REQUIRE GENERAL TAXATION

The question arises as to whether the whole social security system is actuarially unsound and hence may break down or not pay off in full. It seems fair to assume that if social security funds prove to be inadequate to pay the promised benefits, the deficiency will be made up out of general revenue. Since we must make up this extra revenue in the form of general taxes, perhaps we should share in the benefits which we are helping to finance.

(Continued on Page 872)

Arguments Against (Cont'd)

Supreme Court on May 24, 1937. This gimmick has been used to make the program saleable to the public. Could there be a better way to sell a paternalistic or socialistic scheme of compulsory taxation to traditionally independent people than to make its title and terminology synonymous in the people's minds with insurance, one of our oldest and most honored institutions? Insurance provides contractual rights. The Social Security Acts contains the following reservations of power: "The right to alter, amend, or repeal any provision of the act is hereby reserved to the Congress."

OASI, THE FINANCIAL FRANKENSTEIN OF THE CENTURY

The existence of the social security program, financially and politically unsound as it is, constitutes one of the greatest hazards of the century. By 1954, the social security accrued liability had reached the astounding figure of 280 billions dollars, equalling the debt that we have been able to build up in all other ways in the entire history of our country. There appears to be considerable doubt that this liability can be covered by existing social security tax laws.

SOCIAL SECURITY TAX DOLLAR POORLY PROTECTED

There is talk of the protection of the "insurance trust fund." The social security booklet states that "the reserve portion of the trust fund —that is, the part not required for current disbursement—is invested in interest bearing United States government securities." This means that the reserve portion is given by the government to the government in return for government bonds on which interest is to be paid into the "trust fund." This in turn means that the government must pay the government interest and principal in the future so that promised benefits can be paid. That part of the social security tax dollar, not immediately spent for benefits or administration, undoubtedly is used for other government expenses. This is not a way of putting money to work to earn more money. The principal way for this money to come back to the government is through general taxation.

PHYSICIANS DON'T WANT FEDERAL CHARITY

Physicians as a group do not seek federal charity. Persons receiving OASI primary insurance benefits at the end of 1952 had already received on the average, or were to receive $24 for each fifty cents they had paid in taxes plus the fifty cents

(Continued on Page 872)

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Reference: *Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A.* **166***:1019, March 1, 1958.*

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Arguments For (Cont'd)

AVERAGE RETIREMENT AGE OF MEN 68½-69 YEARS OF AGE

The argument is made that only one out of seven doctors retires between the ages of 65 and 72. This carries the implication that all other persons in the social security system retire promptly at the age 65 so that doctors would pay for the retirement costs of others. On the contrary, the average retirement age for men since the OASI system began has been between 68½ and 69.

SOCIAL SECURITY ACCEPTANCE WON'T REGIMENT THE PROFESSION

Compulsory coverage does not mean regimentation of the profession. Self-employed businessmen, who have been covered by OASI since 1951, have not experienced more regimentation than doctors during this time.

CARRYING PRINCIPLE TOO FAR

Social security is obviously here to stay. It is foolish for doctors to miss this "gravy train" ride merely for the sake of principle.

SOCIAL SECURITY FOR DOCTORS DOESN'T MEAN MORE GOVERNMENT IN MEDICINE

The inclusion or exclusion of physicians under OASI, while it is vitally important to us as individuals, cannot itself stimulate further government intrusion in the field of medicine.

DOCTORS HAVE A SOCIAL OBLIGATION TO MEET

If social security coverage were extended to all groups, several benefits to the system itself would flow from the very fact of completeness. This would tend to reduce the proportionate costs of benefits. Most important of all, complete coverage would in a matter of ten years or so reduce the need for public assistance to a bedrock minimum.

PHYSICIANS' STAND IMPORTANT IN PUBLIC RELATIONS

Physicians alone oppose social security coverage. Is this likely to be regarded by the public as a conscientious effort on the part of a militant group of freedom-loving Americans bent upon thwarting a paternalistic government from further socializing the nation? Or, is it likely to be regarded as an effort by a well-heeled profession more concerned with its own selfish interests than with the interests of the nation as a whole? This could be important in our public relations.

Arguments Against (Cont'd)

paid by their employers. The amendments of 1954 boosted the ratio to at least $30 for each fifty cents. Thus, today 96 to 97 per cent of the pension is a gift to the senior citizens from the taxpayers. The argument that we should accept those windfall benefits because almost every eligible citizen will, has little appeal to physicians when their basic struggle is to preserve the free practice of medicine.

OASI DISCRIMINATES AGAINST HIGHER INCOME GROUPS

Although retirement and survivor payments increase according to the amount of taxes paid, the program is weighted in favor of the low income groups. Furthermore, there is every indication that the tax base will be raised from the present $4,200, thereby creating an additional burden on the higher income groups. It has risen 40 per cent in five years; a proposal now before Congress would raise it to $4,800. Each physician might ask himself the following question: If I were a politician anxious to please the largest number of voters, would I favor raising the social security tax base figure so that more benefits could be promised?

PRIVATE COMPANIES OFFER YOUNG DOCTORS BETTER LIFE INSURANCE

Advocates of compulsory coverage for physicians contend that self-employed physicians with young children could well afford to pay the entire social security tax for the sole purpose of obtaining survivorship benefits. Actually, equal or greater benefits can be purchased from life insurance companies at a lower cost. This can be done through decreasing term insurance (family income rider).

ONLY ONE IN SEVEN DOCTORS RETIRES BEFORE AGE 75

Most self-employed physicians do not retire. Currently about six physicians out of seven in the age group 65-75 are engaged in the active practice of medicine. Thus, the provisions of the OASI relative to retirement simply do not fit the economic pattern of the self-employed physician.

GOVERNMENT RESPONSIBILITY SYNONYMOUS WITH INDIVIDUAL IRRESPONSIBILITY

Those favoring social security contend that "the purposes are so worthwhile that we as doctors and humanitarians should back them. They say that social responsibility is part of civilization and that

(Continued on Page 874)

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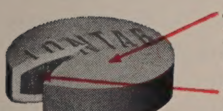

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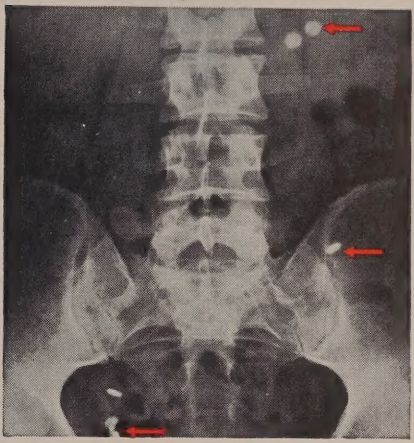

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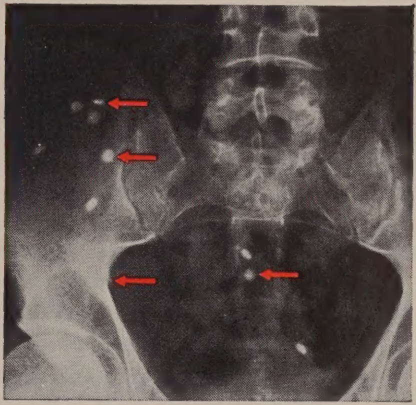
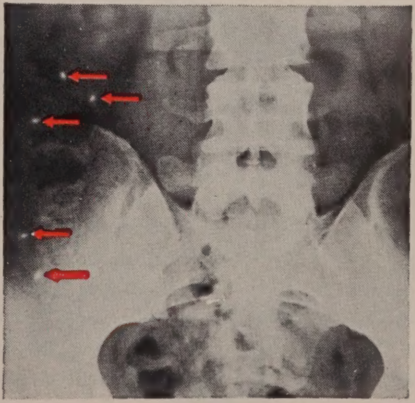


8 hours Lontabs are still visible as substance of core continues to be released.



Arguments Against (Cont'd)

it should increase. Unfortunately in the history of civilization, social (or government in their minds) responsibility has always been synonymous with individual irresponsibility. As the latter grows, economics and civilizations decline and die, or are killed. Those who wish to be "humanitarians" actually have the greatest stakes in keeping social security sound. The self-employed physicians have nothing to be ashamed of in relation to their dollar contribution to humanity at large.

When we see the 'humanitarians' always so ready to give generously of the time, talent, training, energies and incomes of others, making contributions of comparable value to society, then we will listen with more sympathetic, but not less critical ears, to their Utopia—you to pay!—schemes and dreams.

COMPULSORY SOCIAL SECURITY ADVOCATED BY PHYSICIANS FORUM

Most doctors have recently received literature advocating compulsory social security from a group known as the Committee on Social Security for Doctors of the Physicians Forum. The source of this material should immediately cast doubt on the accuracy and objectivity of its message. Most physicians will recall that the Physicians Forum was the only medical organization in the country that supported national compulsory health insurance and will not look kindly on any cause that it supports.

* * *

Analysis by Insurance Man

"MAJOR Issues in the Proposed Coverage of Physicians Under Social Security" was the subject of an address by Benjamin B. Kendrick before the Providence Medical Association, Providence, R. I., on January 7, 1957. Mr. Kendrick of New York City is research associate of the Life Insurance Association of America and editor of the magazine *American Economic Security*. He was formerly Social Security analyst of the United States Chamber of Commerce. The text of his address follows:

This coverage question is quite an important one. If physicians should be brought under the old-age and survivors insurance provisions of the social security legislation—the so-called OASI system—a beginning doctor could anticipate paying social security taxes of up to about $10,000 in the course of a lifetime of practice—and this figure is based on the unlikely assumption that the OASI system will not be further liberalized during his lifetime. When possible liberalizations in the system are taken into account, the physician's lifetime taxes might run a great deal higher. Roughly offsetting these taxes, of course, are the social security benefit expectancies he would gain.

More important than the dollars and cents of it may be some other questions involved. For instance, would the medical profession be able to speak more effectively in Washington on matters relating to social security, if inside or outside the OASI system? Again, is there any right or wrong to the coverage proposal from a standpoint of principle?

Because of the importance of the issues, it is good that the medical profession is devoting increasing attention to the proposal for social security coverage. Let me say, too, that if doctors should decide to seek OASI coverage, they had better be very sure they have reached the right decision—bcause once under the OASI system, it is most unlikely they would ever have a chance to withdraw.

The Physicians Must Decide

It is of course the responsibility of Congress, in its wisdom, to enact and amend the Federal social security laws. However, Congress has never yet extended OASI coverage to any considerable group of people without evidence that the members of the group preponderantly wanted to be under OASI. If spokesmen for the medical profession should tell Congress that doctors want OASI coverage, they would surely acquire it shortly thereafter. Conversely, if medical spokesmen continue to tell Congress that doctors do not want OASI coverage, then I have no doubt that physicians can remain outside the system—at least for some time to come.

Thus, it seems to me, doctors must decide for themselves whether they want to be in or out of OASI. It would certainly be presumptuous of me—or of any other layman—to try to tell the members of the medical profession what they ought to do. What I may be able to contribute tonight is to furnish some relevant information, and some informed guesses, that may assist those present in arriving at their own conclusions.

Voluntary OASI Coverage for Physicians Unlikely

In advance of this meeting, Mr. Farrell thoughtfully sent me a copy of the May 1955 report on the Rhode Island Medical Society's membership poll

(Continued on Page 876)

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Social Security for Physicians (Cont'd.)

as to physician participation in the OASI system. As you know, the report showed that, while the vast majority of the members responding were opposed to compulsory OASI coverage, voluntary coverage for those wishing it was favored by a good majority.

However, there are a number of objections to voluntary OASI coverage for doctors—or for any other group—and I think Congress is well aware of them. The chief argument against voluntary coverage concerns the so-called *adverse selection* involved. In other words, the thought is that those whose prospective benefits stood to be greater than their prospective taxes would tend to choose to be in the system, whereas those whose taxes stood to exceed their benefits would tend to stay out. To the extent these tendencies operated, the voluntary participants would make a *profit* on their coverage. Moreover, assuming the system continues to be run on a self-supporting basis, any profit made by voluntary participants must necessarily be at the long-run expense of the others under OASI, who are almost all covered on a compulsory basis.

Another objection to voluntary coverage relates to what most people agree on as being the system's fundamental purpose—that of furnishing a basic floor of protection for all against want. The argument runs that, under voluntary provisions, those most likely to need the benefits would be the least likely to elect coverage, whereas those least likely to be in need would be the most likely to elect coverage. Perhaps this argument is not entirely applicable to physicians, but certainly there is at least some merit in it.

A third argument is that a governmental program like OASI, dealing with tens of millions of people over scores of years, must be kept relatively simple if it is not to bog down through administrative complexities and costs in sheer bureaucratic weight. And voluntary provisions do mean a great deal of extra complexity that I perhaps need not take the time to spell out.

For these reasons, it seems unlikely that Congress would offer physicians, on an individual basis, the right to accept or reject OASI coverage. I think the actual choice will prove to be between no coverage for any and compulsory coverage for all.

Employed Physicians Already Covered

In saying "no coverage for any," I am of course referring to self-employed physicians. Doctors

(Continued on Page 878)

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Social Security for Physicians (Cont'd.)

employed on a salary, as no doubt you know, are now covered by OASI (and have been since the system's inception), if the employment area itself is inside the system's purview.

Perhaps you are not aware of the extent to which physicians already have OASI coverage. I have some figures on this, based on a sample survey made by the OASI Bureau of the Social Security Administration in 1955.

According to that survey, 45 per cent of the 201,000 physicians listed in the A. M. A. directory had at least some credited earnings under OASI. And 22 per cent of the physicians listed had enough OASI coverage to have a so-called *fully insured* status under the system or to have had such a status at some previous time.

The sample survey, also, studied separately the listed physicians who were in self-employment (presumably private practice in most cases) at the time the survey was made. Such physicians, of course, could have acquired OASI wage credits either before entering private practice or by part-time employment while in private practice. At any rate, of the self-employed physicians, 35 per cent had at least some covered earnings, while 11 per cent had or had had a *fully insured* status.

These figures have probably gone up somewhat since the survey was made. The main reason for thinking so is that there have been several bits of new legislation since then, extending the area of OASI coverage, and hence increasing the proportion of salaried physicians who are covered.

In this regard, let me call your attention to some new legislation extending regular OASI coverage, beginning January 1, 1957, to members of the armed forces. There are also gratuitous OASI wage credits provided for military service between September 15, 1940, and December 31, 1956. Both sets of provisions are fully applicable to service in the uniformed forces in any medical capacity.

I know personally of one case where these provisions have already proven effective. There is a lady employed in our office whose husband had been a physician before his death about two years ago. He had never been under the regular OASI provisions, had never paid a cent in social security taxes, and in fact, did not even have a social security number. However, he had served for about four years in the armed forces during the war. As a result, his widow and four children together have been drawing $66.40 a month in OASI benefits.

The general point I am trying to make is that physicians have a surprisingly large amount of OASI coverage already. The proposal we are discussing can hence be restated as being whether doctors wish OASI coverage for private practice to go with the coverage they already have in salaried employment and during periods of military service.

How Would Doctors Make Out Compared With Others Under OASI?

Let me now turn to the question of whether doctors would get their money's worth out of the OASI system if they were covered under it. This question can best be handled as two separate questions: First, how would doctors make out compared with the general population under OASI? And second, how does the covered population, on an average, make out under OASI? These questions, let me emphasize, relate to compulsory coverage; I have already suggested that physicians would stand to get a good deal more than their money's worth out of the system if they were to have coverage on an optional basis.

No mathematical answer is possible to either of the two questions on compulsory coverage. This is mainly because OASI does not stand still; no one really knows what the system will come to be like in the future. However, I think the questions on how doctors would make out can be answered fairly well—but in non-mathematical terms.

Compared with other people compulsorily covered by OASI, doctors would be better off in one major way, and worse off in another. Doctors would be better off than most others in that, as self-employed persons, they would pay only three-quarters of the combined employer-employee taxes applying to people in covered employment. At the ultimate tax rates, applicable in 1975 and thereafter under the present tax-rate schedule, the self-employed will pay $6\frac{3}{8}$ per cent in contrast with a combined $8\frac{1}{2}$ per cent on employment earnings.

On the other hand, the OASI benefit formula is geared to favor those at the low end of the earnings' scale. Because physicians tend to be near the high end of the scale, this means that the benefit formula is geared to their disadvantage. But the 25 per cent discount that doctors would get on their tax bill may roughly cancel the fact that the benefit formula would be loaded against them.

There are various other minor points about how physicians would fare under OASI, compared with others under the system, of which perhaps only one is worth mentioning. I have frequently heard it argued that doctors would lose out because they do not normally retire at age sixty-five but continue their practices indefinitely. Hence, it is argued, physicians could not draw OASI retirement

(Continued on Page 880)

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Social Security for Physicians (Cont'd.)

benefits because the so-called *work clause* would operate to prevent it.

In my best judgment, there is little real substance to this argument. For one thing, most laymen likewise do not retire at age sixty-five. The statistics show that, so far, the average age at retirement under OASI has been about sixty-nine. Moreover, there is a provision in the OASI legislation that the so-called *work clause* ceases to apply at age seventy-two. And it is not at all far-fetched to think that Congress may reduce this age at which benefits become payable regardless of earnings to seventy.

So, all things considered, I think doctors would make out about as well under compulsory OASI coverage as do people generally.

How Do People Generally Make Out Under OASI?

But does the covered population generally get its money's worth from OASI? On the whole, I think so—but I am speaking now only about the existing system, and not about what it may come to be in the future.

In any event, the aggregate of benefit payments under the system does not differ greatly from the aggregate of tax receipts. Some of the past tax receipts have been used to build up a relatively small reserve fund, which is still increasing slowly. This fund earns interest, which adds to the amounts available for benefits. On the other hand, administrative expenses are paid out of the fund. Concerning administrative expenses, I may say that the OASI program is a huge, mass-production type of operation, and as a result, the administrative costs run only about 2 per cent of the sums taken in or paid out.

In contrast to an insurance company, OASI pays no taxes and employs no salesmen. On the other hand, the interest earnings of OASI are quite small, relatively speaking. This is mainly because the system has operated on nearly a pay-as-you-go basis, and consequently, the reserve fund represents only a small fraction of the accrued liabilities. Also, the funds are invested in Government bonds, which bear a relatively low interest rate.

Of course, there is much more to it than these brief comments indicate. An insurance company guarantees its policy benefits; OASI benefits, on the other hand, are subject to change—or even discontinuance—at the will of Congress, as Section 1104 of the amended Social Security Act explicitly provides. Also, loans can be had against insurance-policy reserves; in OASI there are no loan provisions.

More important, insurance companies offer numerous policies from which the purchaser can carefully select the one best meeting his needs, desires, and premium-paying ability. In OASI, by contrast, there is no choice: One set of benefit and tax provisions applies, willy-nilly, to all.

Perhaps this last point is the heart of the matter. As a social benefit program, designed to meet the minimum needs for protection of the population generally, OASI can be considered a *good buy,* with the participants, on the whole, truly getting their money's worth. However, if OASI should be over-expanded, and attempt to provide full protection for the population, then participants will no longer be getting their money's worth because their taxes will be buying benefits differing, more or less, from what they need, want, and are willing to pay for. And no misfit article, that you are required to use, can be a good buy regardless of the price.

Questions of Principle and Philosophy

More important than the dollars and cents of doctors' coverage under OASI may be questions of principle or philosophy, as I suggested earlier. The trouble is that some people—using one line of argument—arrive at the conclusion physicians certainly should be covered, while others—using another line of argument—conclude that they certainly should not be.

People such as some of my former colleagues at the Social Security Board argue that OASI is designed to furnish universal protection, that the system cannot work with maximum efficiency so long as any important group remains outside it, and that consequently physicians should be brought under the general law. My own feeling is that, while there is some validity to this argument, universal coverage is not really essential. Also, I think it is proper—and in accord with democratic principles—for Congress to take the wishes of the group affected into account.

The opposing view, briefly, is that social security is a step on the road to socialism and worse—and that the medical profession should consequently oppose coverage with vigor. My own feeling is that, while future history might verify the first part of this argument, the second part does not follow. In other words, if broad forces are leading the United States to socialism, the trend could hardly be affected much by the action of physicians on OASI coverage.

All in all, I am personally not convinced that there are over-riding considerations of philosophy

(Continued on Page 882)

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1. Russek, H. I.: Postgrad. Med. *19*:562 (June) 1956.

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Social Security for Physicians (Cont'd.)

or principle either way. Consequently, if I were a physician, I think I would view the question mainly from an economic standpoint, making the best guess I could as to what changes in OASI the future is likely to bring.

Future Changes in OASI

And that leads us to the $64 billion question—how will OASI be shaped in the future? Will the system be over-expanded?

It could happen. Surely Congress will be subject to continual pressure for OASI liberalization—higher benefits, more lenient eligibility requirements, new types of benefits. And it can scarcely be doubted that some liberalizations will be enacted from time to time.

Nevertheless, I am cautiously optimistic that the pressure for continual OASI expansion can be contained fairly well within reasonable bounds. The chief thing that makes me think so is the growing evidence that the repeatedly increased OASI payroll taxes are beginning to become high enough and painful enough to encourage voters to carefully scrutinize all proposals to expand benefits.

During consideration of the bill which became the 1956 Social Security Amendments, Congressmen seemed very conscious of the tax angle. The original bill had provided full benefits for women at age sixty-two, instead of sixty-five, but this provision in conjunction with the new cash disability benefit provisions would have cost employers and employees a tax increase of one per cent of payroll. To avoid such a tax increase, reduced benefits for wives and working women below sixty-five were substituted, with the tax increase being held to one-half of one per cent.

Moreover, it is important to remember that existing law provides a whole schedule of tax increases to take effect between now and 1975. And these tax increases, of course, are required merely to meet the growing costs of the present benefit provisions—they cannot be used to provide additional benefits. When the American people have had to meet the first one or two of these scheduled tax increases, with no corresponding increase in benefits, they will be even less willing than at present to pay still higher taxes for new liberalizations in the benefit provisions.

Possible OASI Liberalizations Affecting Medical Practice

What possible liberalizations in OASI would affect the practice of medicine? Let me devote just a minute or two to this question.

To begin with, as you know, the new cash disability benefit provisions in the 1956 Amendments do affect medical practice. The doctor's role is to make examinations and certifications as to apparently disabling impairments, subject to some supervision from the social security authorities.

There will surely be intense pressure for expansion of these new provisions. Under present legislation, the benefits are available only at age fifty and over, but demands are already heard that they be provided regardless of age.

Moreover, there are no benefits for the wives and children of disability beneficiaries under the new provisions, whereas dependents' benefits are provided under OASI in case of retirement or death. Dependents' benefits in disability cases are sure to be urged.

Also, the 1956 Amendments provide benefits for disabled children. You see, there are two separate things: Benefits for the able-bodied dependents of disabled people, and benefits for the disabled dependents of people who are dead or retired, but not disabled. In any event, the new principle of benefits for disabled dependents could conceivably be carried much further.

Now as to the possibilities for Federal medical-care benefits—that is, socialized medicine—either inside or outside the OASI system. It seems clear that the direct threat of such legislation has largely evaporated. And I think much of the credit is due to the phenomenal growth of voluntary health insurance—both in numbers covered and in the breadth and depth of their protection. Here I think the insurance companies—along with Blue Cross and Blue Shield—are entitled to take a bow.

The Achilles heel in the body of voluntary health insurance may be in the limited extent to which the retired aged are protected. There seem to be growing demands that OASI be expanded to include medical-care benefits for old-age beneficiaries. Incidentally, this proposal is not new; you may recall that Oscar Ewing was urging the same general plan when he was Federal Security Administrator.

If the past is any guide, it seems likely that voluntary health insurance will solve the problem of providing more adequate protection for the retired aged. In particular, there are encouraging new developments in adding group health insurance protection for retired employees to employer and union welfare programs.

However, voluntary health insurance cannot do the entire job over night. The new policies mainly give protection in retirement to employees now active. For a temporary period, there will continue to be a partial vacancy—enticing to the proponents

(Continued on Page 884)

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[1] Meprobamate is more widely prescribed than any other tranquilizer. Source: Independent research organization; name on request.

[2] Baird, H. W., III: A comparison of Meprospan (sustained action meprobamate capsule) with other tranquilizing and relaxing agents in children. Submitted for publication, 1958.

*TRADE-MARK CME-7326

Social Security for Physicians (Cont'd.)

of compulsory health insurance. If their noses should enter the tent, a general socialized medicine program might follow.

Could the Profession Speak Best Inside or Outside of OASI?

This foreboding possibility leads to a question I raised at the outset—would the medical profession be able to speak more effectively in Washington on social security matters, if inside or outside the OASI system? As I see it, there are three answers to this question, depending on the type of matter being considered.

If this issue is one affecting the practice of medicine—such as a proposal to add more disability benefits or some medical-care benefits to OASI—then doctors are qualified to testify as experts. On such an issue, I think it would make little if any difference whether the doctors were themselves covered by the system.

If the issue is a general social security one, not affecting the practice of medicine, then it seems to me, doctors would have little reason to testify, and little weight if they did, unless they were themselves covered by OASI. I can imagine a Congressman thinking: "What business is it of the doctors to concern themselves with a proposed increase in social security taxes and benefits, if they are themselves outside the system?"

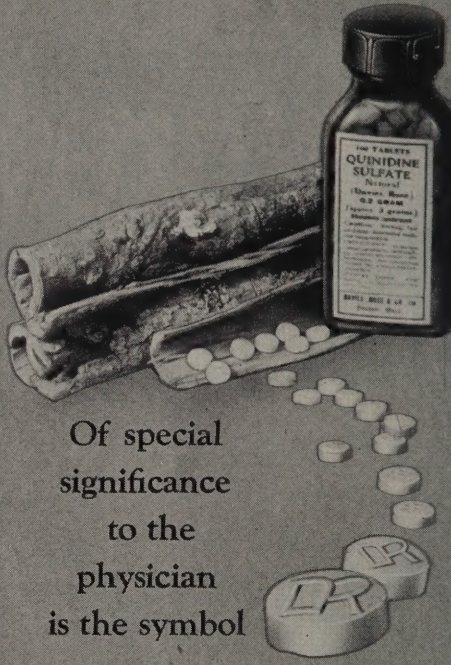
The third kind of issue I have in mind is the sort posed by the so-called Jenkins-Keogh Bill. This proposal is one to give favorable income-tax treatment to sums set aside for their retirement by doctors and by other self-employed people. Here I can imagine a Congressman asking: "Why should we give doctors this special tax treatment, when they are unwilling to come under the general retirement system Congress has set up?"

Conclusion

Well, I have finished outlining what seem to me to be the major issues raised by the proposed OASI coverage of physicians. And I have indicated my own thoughts about each.

In conclusion, I must confess it all adds up to nearly nothing—in other words, that the *cons* just about balance the *pros*. Perhaps, as I see it, there is a bit more to be said in favor of OASI coverage for doctors than against it. However, the difference is not great. And, depending on the relative importance one attaches to the various points, he could easily reach the opposite conclusion.

Gentlemen, it is your decision. It is your views which will decide the question, not mine. Thank you.



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You and Your AMA

Some Highlights and Sidelights on the American Medical Association's Activities and Program

Dr. Gunnar Gundersen—112th President

In taking the oath of office as 112th president of the American Medical Association June 24 in San Francisco, Dr. Gunnar Gundersen called attention to the physician's obligations on the international scene. The 61-year-old LaCrosse, Wis., surgeon said: "As both physicians and citizens, we must see that medicine plays its full role, not only in promoting better world health, but also in helping the search for brotherhood and peace."

As American citizens, Dr. Gundersen said, "our first duty is to this country. But as members of the brotherhood of man, we also have a duty toward all men who yearn for freedom, dignity and peace." He further pointed out that "medicine can play a vitally effective part in bringing reality to the dream of world peace. For medicine, despite the designs of politicians or dictators, is above the harsh conflicts of ideologies and power policies. Medicine, like religion, speaks a universal language which passes all barriers of race, creed, color and nationality."

Meeting on Chemical Products

The AMA's Committee on Toxicology will conduct a meeting July 25 at AMA Headquarters in Chicago to discuss proposed legislation requiring the declaration of hazardous ingredients and warning statements on the label and in the accompanying literature of household, commercial and industrial chemical products. Representatives of interested industries and trade associations also will attend. Further information may be secured from the Committee.

New Exhibit on Fitness

"Seven Paths to Fitness" is the title of a new American Medical Association exhibit slated for debut at the Public Relations Institute August 27-28 in Chicago. Sponsored by the Bureau of Health Education in cooperation with the Bureau of Exhibits, the new display emphasizes the following seven avenues to health and fitness: Nutrition, relaxation, play, exercise, dental care, medical care and work. Over-all murals depict the sources and activities in each category. The exhibit is primarily intended for professional audiences such as physicians, educators and others having a direct interest in physical fitness. It will be available for bookings after September 1 through the Bureau of Exhibits. A smaller type exhibit on the same subject will be completed later.

Sets August 27-28 For PR Institute

Be sure to circle the dates of Wednesday and Thursday, August 27 and 28, on your calendar for the American Medical Association's 1958 Public Relations Institute at the Drake Hotel, Chicago. The meeting will be of particular interest to state and county medical society executives, public relations personnel and public relations chairmen. Further details will be announced later.

Films of AMA Annual Meeting

Filmed highlights of the AMA's 107th Annual Meeting—presented by the American Medical Association in cooperation with Merck, Sharp & Dohme—will be available after September 1 for showing to medical meetings. Entitled "San Francisco—1958" (TV Abstracts of the AMA Annual Meeting), the 40-minute black and white films taken from kinescopes of five daily television programs may be secured either from the AMA Film Library or Merck, Sharp & Dohme, Philadelphia 1, Penna. These programs will feature interviews with speakers on the convention program.

New Films Added

Two more film subjects from the fracture series produced for the Veterans Administration have been added to the AMA film library. "Fractures about the Knee" was reviewed in the *AMA Journal,* Jan. 26, 1957, page 308. These two basic teaching films on fractures incorporate diagrammatic illustrations and excellent photography.

A highly recommended teaching film from the Mayo Clinic also has been added to the film library. "Technique of Proctoscopy" was the subject of an illustrated film review appearing in the *AMA Journal,* March 22, 1958, page 1510. This film is a portrayal, step by step, from the taking of the proctologic history to the completion of the proctosigmoidoscopic examination.

High School Scientists Exhibit

The American Medical Association was host to two teen-age scientists during its Annual Meeting in San Francisco. As a result of their winning the AMA's top citations at the National Science Fair in Flint, Mich., May 7-10, Clare L. Chatland, 16, Missoula, Mont., and David R. Brown, 15, Minneapolis, Minn., showed their exhibits to 30,000 physicians and guests at the San Francisco meeting.

In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

WORKSHOP SHOWS IMPORTANCE OF DOCTOR - WRITER COOPERATION

Cooperation between the physician and the news media writer pays dividends. This was vividly brought out at the Medical Writing Workshop conducted jointly by the AMA and National Association of Science Writers, May 22, in Cincinnati.

The science writers and the physicians readily agreed that this cooperation has produced accurate and informative medical news written in lay terms for lay consumption. It has helped to give the laymen a better understanding of the physician and the medical profession.

Physicians have learned that reporters in almost every instance are anxious to write accurately and appreciate the assistance they can obtain from the medical profession. Reporters also have learned that medical men want to check their reports not for editing or censorship, but rather to make certain that nothing has gone astray in the transition from medical terminology to lay reading.

Since only a few Ohio newspapers have full-time science writers, most physicians in the state find themselves confronted with general reporters with not much experience in the science news field.

In our opinion, it is in the best interests of the physician and his profession to befriend, cooperate with and assist these reporters. The end results are well worth the effort.

SAVE JUDICIAL COUNCIL OPINIONS FOR REFERENCE

The principles of Medical Ethics and Opinions and Reports of the Judicial Council, abstracted and annotated, were published in a special edition of the June 7 issue of the *AMA Journal*.

For the first time in the Association's history, opinions and reports of the Judicial Council interpreting the Principles of Medical Ethics have been assembled and made available to all members of the Association. Not only does this compilation include interpretations of the Principles by the Council but it also includes the several sections of the 1955 edition of the Principles.

This was thought desirable in order to preserve the language used in the past to express ethical concepts. It serves also to emphasize that the short (1957) version of the Principles does contain the spirit and intent of previous, longer versions.

This document should be valuable to all physicians and especially to those whose duties include serving on boards of censors or similar committees. Every physician should become familiar with the contents of this document and preserve it for future reference.

CLYDE CUMMER MADE MANY CONTRIBUTIONS

Many within and outside the medical profession were saddened to learn of the death of Dr. Clyde L. Cummer, Cleveland, who served as President of the Ohio State Medical Association in 1933-34.

Dr. Cummer was outstanding among the long list of distinguished leaders of the Association.

In addition to being a great scholar, fine teacher, and expert in his chosen specialty, Dr. Cummer was almost a genius in organization activities. He not only knew how to organize for an event or project but he possessed the know-how and follow-through needed to get the job done. The many honors which he received over the years from professional and non-professional groups are testimonials to his efficiency and the respect which others had for his initiative and rare abilities.

Add to these attributes, the fact that Clyde Cummer was the finest of gentlemen—one who never found it too much trouble to do a good turn for a friend or for any one of the medical societies to which he belonged.

Dr. Cummer's contributions were many. Because of him, many, including the organizations to which he devoted much time and effort, have richly benefitted.

"VITAL POLIO PROGRAM"— AN EXCELLENT EDITORIAL

In our opinion an editorial entitled "Vital Polio Program" published on May 5 by the *Youngstown Vindicator* contains a carload of common sense. It is an exceedingly realistic, as well as sound, observation on the controversy as to how a polio immunization program should be handled. It lends strong support to the basic policy of the Ohio State Medical Association on this subject—a policy concurred in by most of the county medical societies of the state, including the Mahoning County Medical Society.

The editorial is lengthy. Nevertheless, because of its importance it is reproduced here with the hope that medical societies in other counties may

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Sulfaguanidine	2 Gm.
Pectin	225 mg.
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Opium tincture	0.08 cc.

(equivalent to 2 cc. paregoric)

DOSAGE: **Adults:** Initially 1 or 2 tablespoons from four to six times daily, or 1 or 2 teaspoons after each loose bowel movement; reduce dosage as diarrhea subsides.

Children: ½ teaspoon (=2.5 cc.) per 15 lb. of body weight every four hours day and night until stools are reduced to five daily, then every eight hours for three days.

SUPPLIED: *Bottles of 16 fl. oz.*
Exempt Narcotic. Available on Prescription Only.

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be able to use its content to advantage in their public relations. Said the *Vindicator:*

"The precise method to be used in providing immunization against polio is not the most important part of the program. Certain procedures must be followed, of course, but the first consideration should be the elimination of unnecessary delays, plus positive action to establish and maintain an effective inoculation campaign, the end of which is not now in sight.

"In many cases, parents or heads of family groups are accepting responsibility in the health program instead of allowing schools or other agencies to shoulder the entire burden. It's hard to see why this practice is not general, considering the fact that so much is at stake. Preventive action is much simpler, and far less expensive, than rehabilitation.

"Basically, this is the kind of program which the Mahoning County Medical Society approves. The society has been trying to impress upon everyone 40 years of age or under the importance of considering polio immunization as a personal matter which demands some initiative on the part of the individual.

The physicians have no quarrel with the fundamental idea in mass inoculations in the schools. However, they fear that this plan may tend to produce in the public mind a false sense of security, with the result that less attention would be given to immunization, which is equally important, among pre-school children and adults under 40 years of age. Parents, they say, may be inclined to delay inoculation of children of preschool age on the doubtful assumption that the vaccine would always be available in the schools. Even if it is, who is to guarantee the child's health until that stage?

"The Medical Society is considering sending a letter to the parents of all school children in the county, including public, parochial and county schools, inviting them to receive the polio shots in their doctors' offices. This seems to be worthwhile because it will bring together doctor and parents for a personal discussion of each child's health problems and both the doctor and the family will be better satisfied.

"In order to be successful, the plan must have the cooperation of parents themselves, health authorities and the schools. There is no question about school cooperation; and health officials would certainly go along with the program. Any lack of family cooperation would be unthinkable.

"Much has been said about the fact that school inoculations would be free. This is a fact, but it is also true that the vaccine would be provided free in doctors' offices if there were a doubt as to ability to pay. Physicians probably have already given away more vaccine than they have been paid for.

"As Medical Society officers explain, the polio campaign is not based on economics; it is intended as an education in health. A few simple facts stand out: The need for immunization is undeniable; there is an abundance of vaccine; it will be given free, and willingly, where needed. Whatever plan is followed—mass inoculations in the schools, or in the doctors' offices—the results are bound to be good as long as the coverage is thorough."

BIG ENOUGH TO GIVE ALL, BIG ENOUGH TO TAKE ALL

Heard Dr. Allman, president of the AMA, hand out this quickie the other day:

"Any government that gets big enough to give everyone everything they want will be big enough to take away from them everything they've got."

Makes a lot of sense, doesn't it?

Quote it to the next chap—maybe a physician—when he starts advocating that government should do this or that—with its money (the taxpayers' money, of course).

DOCTOR HAS BIG STAKE IN HIGHWAY SAFETY

Highway safety is an ever-present concern for many physicians in Ohio.

The House of Delegates of the OSMA apparently agrees. At the recent Cincinnati meeting it endorsed a proposal to bring about highway safety in Ohio and authorized President Woodhouse to name a special committee for this purpose.

Many doctors are doing their part along with other citizens of their communities by participating in local safety programs and by working with organizations concerned with this problem. Much more needs to be done.

Citizens are likely to be lulled into complacency by the ever-present toll of traffic accidents. Although perhaps not expressed, the attitude often is: "It's not much greater than it was a year ago."

Highway Safety Director Gordon Jeffery pointed up the toll recently when he compared the total for a year with the populations of certain communities. If the entire population of a town of 2,000 were wiped out in a year's time, people would take notice. Yet that is less than the number of deaths in Ohio during 1957 from traffic accidents, and people do not take notice.

If the entire population of a city the size of Springfield (more than 78,000) were injured in a catastrophy, the entire population of the state would take steps to prevent a recurrence. Yet more than that number were injured in traffic accidents in the state last year.

Physicians are not exempt. A quick scan of doctors' deaths during 1957 shows that at least four Ohio physicians died as a direct result of traffic accidents.

Perhaps the answer is one of the well-known

when eating moves outdoors . . .

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three E's—education, enforcement, engineering. Perhaps there is another answer. But whatever the solution to so great a problem, it behooves every doctor to study the problem and offer his services in whatever capacity he believes most fitting.

All members will be called upon for cooperation by the new committee as soon as it gets its program underway.

ACTIVITY OF AUXILIARY DRAWS DESERVED PRAISE

A recent tea which the Ottawa County Medical Society Auxiliary gave for some 100 girls from three high schools has drawn editorial praise of a Port Clinton newspaper.

The tea was arranged in order to draw to the attention of the high school girls the need for registered and practical nurses, dietitians and medical technicians.

Many county auxiliaries throughout the state are actively engaged in this same pursuit. This not only helps to provide future members of these allied professions but also demonstrates clearly that these fields have the interest and well wishes of the medical profession.

TO GIVE OR NOT TO GIVE, THE RECORDS

It's not uncommon for a physician to have one of his patients ask him for a copy of the records in his case. What should the physician do? What are the ethical and public relations angles? Here's what the Judicial Council of the AMA had to say on this question:

The principles of medical ethics do not intend or require that a physician give a copy of his records to his patient, the council believes. These records are primarily the physician's own notes compiled during the course of diagnosis and treatment so that he may review and study the course of the illness and his treatment. The records are medical and technical, personal and often informal. Standing alone they are meaningless to the patient but of value to the physician and perhaps to a succeeding physician.

The patient, however, or one responsible for him, is entitled to know the nature of the illness and the general course or regimen of therapy employed by his physician. The extent to which the physician must advise his patient may be limited by the nature of the illness and the character of the patient. The physician in advising his patient must always act as he would wish to be treated were he in a like situation.

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SURGERY—Surgical Technic, two weeks, Aug. 18, Sept. 15. Surgery of Colon and Rectum, one week, Sept. 22, Oct. 27. Basic Principles in General Surgery, two weeks, Oct. 13. Esophageal Surgery, one week, Sept. 15. Thoracic Surgery, one week, Sept. 22. Gallbladder Surgery, three days, Nov. 3. Surgery of Hernia, three days, Nov. 6. General Surgery, two weeks, Nov. 10; one week, Oct. 27. Fractures & Traumatic Surgery, two weeks, Oct. 20. Treatment of Varicose Veins, two days, Sept. 15. American Board Review Course, two weeks, Nov. 10. Blood Vessel Surgery, one week, Oct. 20.

GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, two weeks, Sept. 8. Vaginal Approach to Pelvic Surgery, one week, Oct. 6. General & Surgical Obstetrics, two weeks, Sept. 22.

MEDICINE—General Review Course, two weeks, Oct. 20. Electrocardiography, two-week basic course, Oct. 6. Gastroscopy & Gastroenterology, two weeks, Nov. 3. American Board Review Course, one week, Sept. 29, (for Part I Candidates only).

DERMATOLOGY—Clinical & Didactic Course, two weeks, Nov. 3.

RADIOLOGY—Diagnostic X-Ray, two weeks, Sept. 22. Clinical Uses of Radioisotopes, two weeks, Sept. 29.

UROLOGY—Two-week intensive course, Oct. 13. Ten-day practical course in Cystoscopy by appointment.

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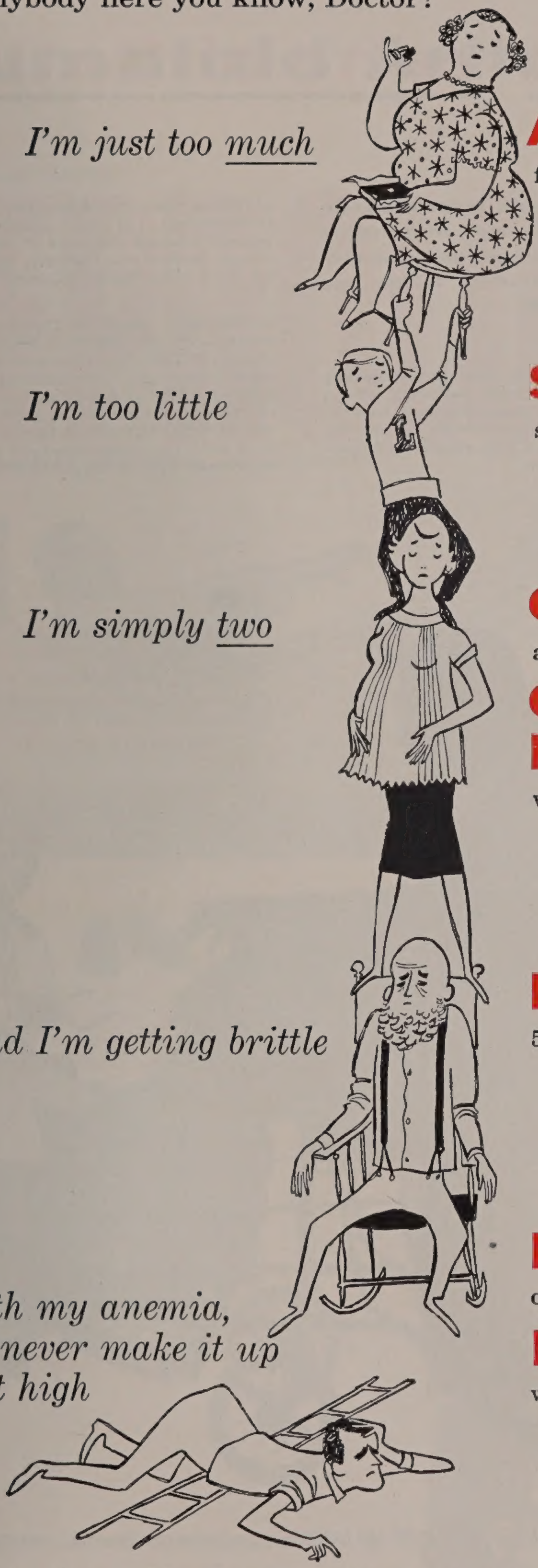

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for sound obesity management
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I'm too little

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stimulates appetite and growth
vitamins B$_1$, B$_6$, B$_{12}$, C and L-lysine

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when anemia complicates pregnancy

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5-factor geriatric formula
hormonal, hematinic and nutritional support

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I'll never make it up
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Joint inflammation and muscle spasm are the two elements most responsible for disability in rheumatic-arthritic disorders—and MEPROLONE is the one agent that treats both.

MEPROLONE suppresses the inflammatory process and simultaneously relieves aching and stiffness caused by muscle spasm, to provide greater therapeutic benefits and a shorter rehabilitation period than any single antirheumatic-antiarthritic agent.

MEPROLONE-2 is indicated in cases of severe involvement, yet often leads to a reduction of steroid dosage because of its muscle-relaxant action. When involvement is only moderately severe or mild, MEPROLONE-1 may be indicated.

SUPPLIED: Multiple Compressed Tablets in three formulas: MEPROLONE-2—2.0 mg. prednisolone, 200 mg. meprobamate and 200 mg. dried aluminum hydroxide gel (bottles of 100). MEPROLONE-1 supplies 1.0 mg. prednisolone in the same formula as MEPROLONE-2 (bottles of 100). MEPROLONE-5—5.0 mg. prednisolone, 400 mg. meprobamate and 200 mg. dried aluminum hydroxide gel (bottles of 30).

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Because muscles move joints, both muscle spasm and joint inflammation must be considered in treating the rheumatic-arthritic patient . . .

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Rheumatoid Arthritis

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MEPROLONE is the one antirheumatic-antiarthritic that exerts a simultaneous action to relax muscles in spasm and to suppress joint inflammation . . .

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Therefore, MEPROLONE does more than any single agent to help the physician shorten the time between disability and employability.

MEPROLONE is a trade-mark of Merck & Co., Inc.

Washington Roundup . . .

News from the Nation's Capital of Interest to Physicians; Developments in Medical and Health Fields

AMA has told official Washington that a strengthened Federal civil defense program should include maintaining at top level health and medical functions of Federal Civil Defense Administration and Office of Defense Mobilization.

* * *

President Eisenhower has appealed for greater use of Salk polio vaccine, following a report to him made jointly by PHS and NFIP that "among the 111 million persons under 40 years, only 49 million have received the full course of three injections, and 46.5 million have received none."

* * *

National Heart Institute reports two of its researchers have found that instead of stimulating the heart as it ordinarily does, adrenalin when used in combination with digitalis depresses the heart and body temperatures are lowered by hypothermia.

* * *

American Association of Medical Colleges has reported that the nation's 85 medical schools will require $275 million for rehabilitation and new construction in the next few years; about $25 million is needed for rehabilitation. This total does not include research and hospital construction. Recent AAMC survey showed that meeting these needs would enable the schools to graduate an additional 1,000 physicians yearly, bringing total yearly graduates to 8,000.

* * *

New chief of PHS Bureau of Medical Services is Dr. James V. Lowry, upped from deputy chief following the March 26 death of native Ohioan Dr. John W. Cronin. Position carries the rank of assistant surgeon general.

* * *

First quarter of 1958 saw Federal government donate surplus property, for which it had paid $81,919,998, to the states for free distribution among public health, civil defense and educational activities. Every state and territory received some surplus.

* * *

Public Health Service reports that in last six months of 1957, 24,953,000 persons suffered injuries requiring medical attention and limiting their activities for at least one day. Forty per cent were involved in home accidents, 10 per cent in motor vehicle and 16 per cent in occupational accidents. Nearly 60 per cent were males; nearly 60 per cent were urban residents.

* * *

Meeting recently in Washington, National Academy of Sciences included Dr. John Holmes Dingle, professor of preventive medicine at Western Reserve University School of Medicine among the 30 new persons elected to membership in the Academy.

* * *

Internal Revenue Service has ruled that physicians in full-time employ of hospitals may exclude from income payments patients make to those physicians so long as the checks are endorsed over to the hospital. However, tax return schedules must show such sources, amounts received and disposition made.

* * *

Federal Trade Commission has ordered Bishop Hair Experts, of Cincinnati, to desist in making certain claims for its products. Order followed testimony by three dermatologists alleging the claims were false.

* * *

Food and Drug Administration reports its agents hard put to keep up with increasing complaints about questionable medicinals and do-it-yourself therapeutic devices. In one month 24 seizures were made, of which 17 were alleged to be false and misleading claims.

* * *

Veterans Administration in May cancelled all plans for reductions in employes and hospital beds after deficiency appropriation of $2.4 million was signed by the President. VA said fiscal shortage resulted in drop in agency's collections from insurance companies for hospitalization of insured veterans.

* * *

National Academy of Sciences and National Research Council have joined American Heart Association in warning against any "major changes" in U. S. diet until more is learned about role of cholesterol in heart disease since "the question of how much and what kind of fat we should eat remains unanswered."

Low Dosage KYNEX* for G.U. Infections

Sulfamethoxypyridazine Lederle

Only One tablet a Day

Unusual Antibacterial and Anti-infective Properties—More soluble in acid urine[1] . . . higher and better sustained plasma levels than any other known and useful antibacterial sulfonamide.[2]

Unprecedented Low Dosage—Less sulfa for the kidney to cope with . . . yet fully effective. A single daily dose of 0.5 to 1.0 Gm. maintains higher plasma levels than 4 to 6 Gm. daily of other sulfonamides—a notable asset in prolonged therapy.[2]

Dosage: The recommended adult dose is 1 Gm. (2 tablets) the first day, followed by 0.5 Gm. (1 tablet) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours.

KYNEX—WHEREVER SULFA THERAPY IS INDICATED

Tablets: Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

Syrup: Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

references:

1 Grieble, H.G., and Jackson, G.G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958

2. Editorial: *New England J. Med.* 258:48-49, 1958.

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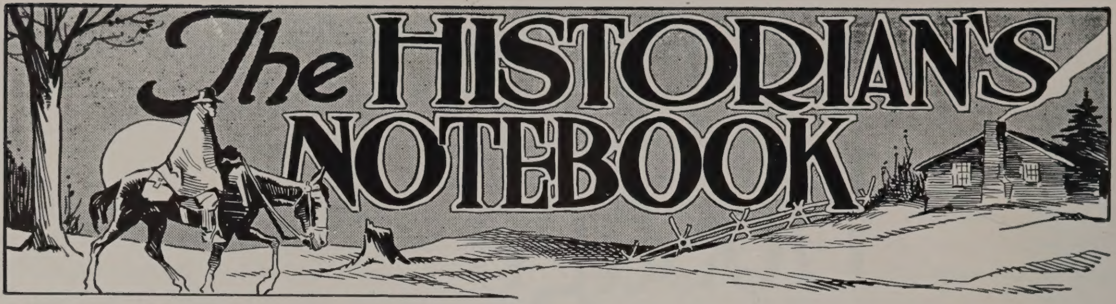


Biological Economics

MARTIN FISCHER, M. D.

PART II

(Concluded from June Issue)

NOW what has all this to do with you? A great deal, I venture to suggest, both in the material world and in that of the spiritual. Under first head I have tried to convince you that nothing physiologically superior, is attained without work. Hence this easy dispositon of all those who, like Reuther, wish to get more and more for less and less; and of the ideals of the communists, the socialists and the do-gooders who would make distribution to everybody's needs from an empty sack.

Don't Sneer

Luncheon clubs have long been sneered at. You are primarily "business" men, they tell you, with the term carrying an uncomplimentary connotation. You are not "professional," so they say, on which account we must define our terms. The professional is the man who gives more than he receives and makes no usurious charge for the material or the service he supplies. It is on this account that the doctor ranks highest even in the learned professions—the priest lacks knowledge of the material world; and the lawyer has too much of it.

Of Business and Men

Wherewith we come to the business man who, too, has within himself all the potentialities of the professional.

I cite Richard Cobden, my favorite of the economists (1804 - 1865) in illustration. At thirty, he was a successful merchant, a printer of goods and a rich man. Wearied in his success, he entered Parliament to stand against the corn laws and for the principles of free trade. Listen to this prediction of his, made circa 1850: "Peace will come to this earth when her peoples will have as much as possible to do with each other; their governments, the least possible."

The Author

● Dr. Fischer, Cincinnati, is emeritus professor of physiology, University of Cincinnati College of Medicine.

Laughter Is in Order

My students used to amuse themselves by their examinations into my politics. I was not a Republican (spelled with a capital), I told them, because the Republicans are the lowest form of all political life—except of course the Democrats (again spelled with a capital) who are lower still. If you really want to know what is my politics, be informed that I am a Cleveland Democrat, an anti-imperialist, a free trader and a carrier of the gold standard. More tersely put, I am the dodo.

Fundamentalist

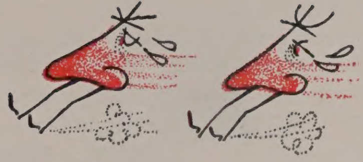
But let us get back to Cobden, 1843, and his estimate of the business man:

> "In the close council of every king, or president, or prince, should be a man of affairs whose life is devoted to commerce and labor, and the needs and requirements of peace. His work is of far greater moment than that of men-of-war.
>
> "Battleships ever form a suggestion for their use, and as long as we have armies, men will kill, fight and destroy. Soldiers who do not

---

Read before the Kiwanis Club, Covington, Kentucky, July 17, 1957.

running noses . . .



and other hay fever symptoms

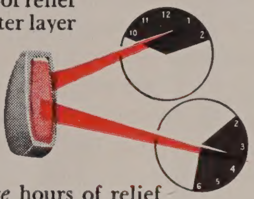
TRIAMINIC stops rhinorrhea, congestion and other distressing symptoms of summer allergies, including hay fever. Running nose, watery eyes and sneezing are best relieved by antihistamine *plus* decongestant action — systemically — with TRIAMINIC.

This new approach frequently succeeds where less complete therapy has failed. It is not enough merely to use histamine antagonists; ideally, therapy must be aimed also at the congestion of the nasal mucosa. Triaminic provides such effective combined therapy in a single timed-release tablet.

TRIAMINIC brings relief in minutes—lasts for hours. Running noses stop, congested noses open—and stay open for 6 to 8 hours.

Triaminic provides around-the-clock freedom from allergic congestion with just one tablet t.i.d. because of the special timed-release design.

first—3 to 4 hours of relief from the outer layer



then—3 to 4 *more* hours of relief from the inner core

Dosage: One tablet in the morning, mid-afternoon and at bedtime. In postnasal drip, one tablet at bedtime is usually sufficient.

Each timed-release TRIAMINIC Tablet contains:

Phenylpropanolamine HCl	50 mg.
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Pyrilamine maleate	25 mg.

TRIAMINIC FOR THE PEDIATRIC PATIENT

TRIAMINIC Juvelets*, providing easy-to-swallow half-dosages for the 6- to 12-year-old child, with the timed-release construction for prolonged relief.

*Trademark.

TRIAMINIC Syrup, for those children and adults who prefer a liquid medication. Each 5 ml. teaspoonful is equivalent to ¼ Triaminic Tablet or ½ Triaminic Juvelet.

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SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska • Peterborough, Canada want to fight are not of this earth. Prepare for war and war will come. When government gives to the arts of peace the same thought and attention that it gives to the arts of war, we will have peace on earth and good-will among men. But so long as the soldier takes precedence of the business man in the political courts of the world, famine, death, disease and want will crouch at our doors.

"Commerce is production, war is destruction. The laws of production and distribution must and will be made a science; and then and not until then will happiness come to mankind and this earth serve as a pattern for the paradise of another life, instead of being a pandemonium."

From the Material to the Spiritual

What I have tried to say has been better phrased many times. I quote from Elbert Hubbard: "Once, a businessman was a person who not only thrived by taking advantage of the necessities of people, but who also banked on their ignorance of values. But all wise men now know that the way to help yourself is to help humanity. We benefit ourselves only as we benefit others. And the recognition of these truths is what has today placed the business man at the head—he ministers to the necessities of humanity. . . . There are no menial tasks. The physical reacts on the spiritual and the spiritual on the physical, and, rightly understood, are one and the same thing. We live in a world of spirit and our bodies are the physical manifestation of a spiritual thing, which for lack of a better word we call 'God.'

"We change men by changing their environment. Commerce changes the environment and gives us a better society. To supply water, better sanitary appliances, better heating apparatus, better food, served in a more dainty way—these are tasks worthy of the highest intelligence. We have ceased to separate the secular from the sacred. That is sacred which serves."

The Challenge

I close by asking you to substitute in your mind's eye for the *threat* of leisure, the *challenge* of leisure. Where might it lie?

The problem of sickness as a cause for the sorrows of mankind is being well licked. In 1900 the life expectancy of us in the United States stood at scarce 50 years. Today it is over 70. And we are not going to be held here, for the biologically calculated life expectancy of man is 140 years. With what and how do you propose to fill in this added time?

The Malthusian law since its birth in the early years of the last century continues—so many live as can live miserably or are content to live miserably. More and better food are demanded to feed the ever increasing world population. Need for the solution of this problem seems so far removed that we will not consider it.

So let us take one closer to hand and more definitely in the category of what the businessman can do to aid. We do not hear much from the customs unions of today, even though I consider their debatings the most fundamental for the solution of our political problems. Open trade made Britain the empire! The obliteration of a customs barrier allowed Austria and Germany to unite. It was a union of free trading states and provinces that melted into Germany; and always remember the history of the Hanseatic League.

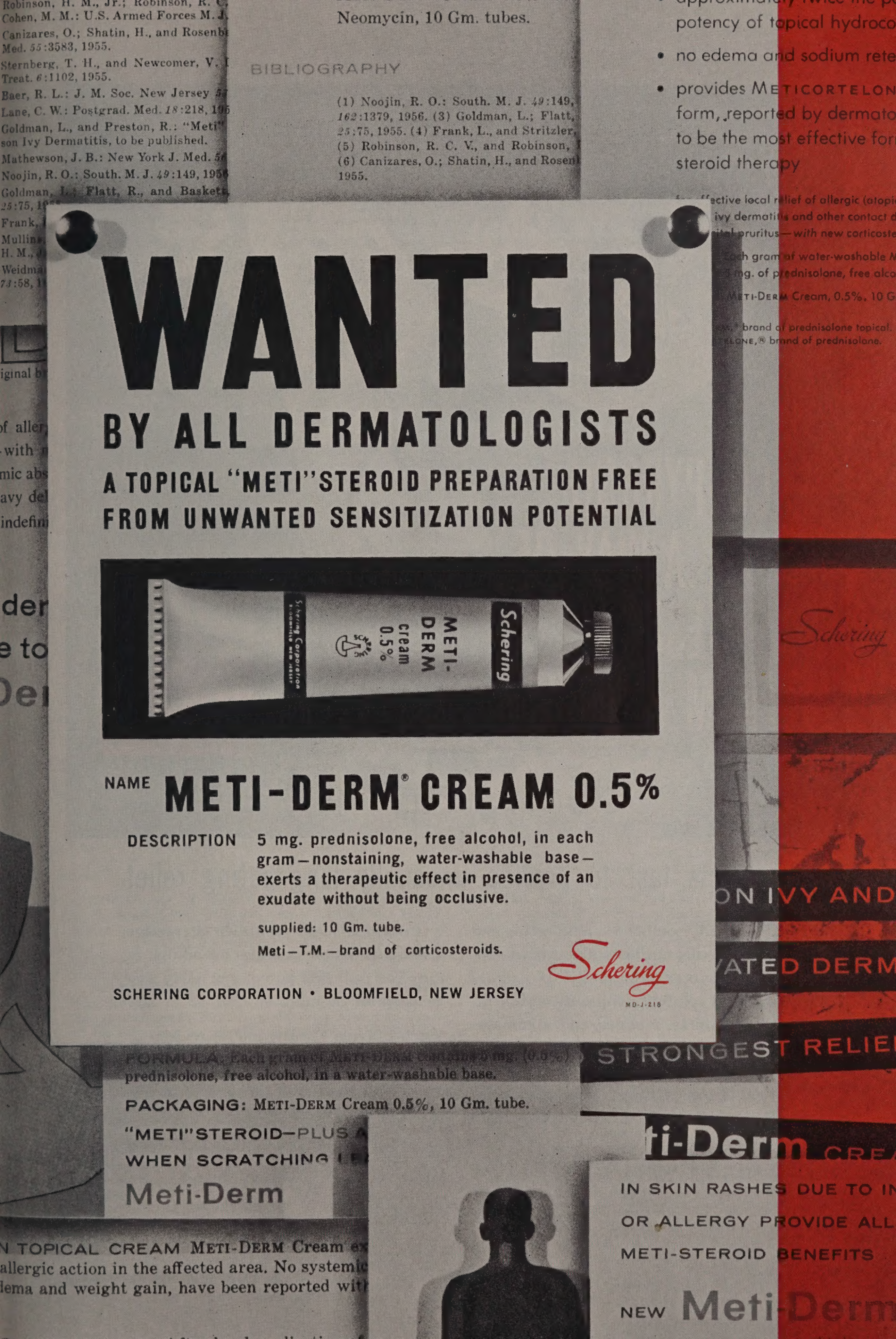
Farewell

Don't forget that all these items were the thoughts and works of business men!

As Phillips Brooks put it, "Do not pray for easy lives; pray to be stronger men!"

The Historical Background of Chemistry, by Henry M. Leicester, Ph.D. ($6.00. *John Wiley and Sons, Inc., New York 16, N. Y.)* The author, an outstanding student of the history of chemistry, is well known to many Ohioans for his teaching days at Oberlin College and work for the Midgeley Foundation at Ohio State University. This book has a greater appeal to the reader because it develops the story of chemistry through the thoughts and ideas of chemists rather than through the details of their lives. Basic ideas arise in various places. Gradually these are united, modified, supplemented and at last announced in what appears to be a new concept. This concept in turn influences and alters subsequent theories and so the potentially endless progress of science results.

The Person Behind the Disease, by Julius Bauer, ($3.50, *Grune and Stratton, New York 16, New York.)* This book's objective is to elaborate on the fundamental principles of the holistic concept of medicine. The author feels that this concept has been threatened by the tendency to split off more and more branches from the tree of the science and the art of preventing, curing or alleviating human ailments, that is by the ever-increasing specialization in medicine. This concept dates back to the days of Plato who first realized the simultaneous involvement of mind and body during physical illness. This was actually the birth of what we call today psychosomatic medicine. There was a long way to go, however, from the intuitive concept of psychosomatic unity to the hallucination of its nature, its mechanisms and its scientific application to the practice of medicine.



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Neomycin, 10 Gm. tubes.

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'Co-Pyronil' combines a long-acting and a short-acting antihistamine with a synergistic sympathomimetic. It usually begins to combat symptoms within fifteen to thirty minutes and eliminates them for as long as twelve hours. Thus you can give your hay-fever patients and other allergy victims remarkably complete relief on a dosage of only 2 or 3 pulvules daily.

Prescribe 'Co-Pyronil' in attractive green-and-yellow pulvules for adults; in tiny red pediatric pulvules or tasty suspension for children.

Each Pulvule 'Co-Pyronil' provides:

'Pyronil' (Pyrrobutamine, Lilly)	15 mg.
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Vol. 54 July, 1958 No. 7

JONATHAN FORMAN, M. D., *Editor*

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Asst. Managing Editor

Rudimentary Varicelliform Eruption—Case Reports And Diagnostic Considerations

ROBERT BRANDT, M. D.

VARICELLIFORM eruption is a clinical, not an etiological entity. It consists of a disseminated vesicular to pustular rash, usually accompanied by high fever and other severe systemic reactions, and is superimposed on a preceding dermatosis. The pre-existing dermatosis is mostly atopic dermatitis, predominantly in children; the superimposed disease was first declared to be vaccinia, but it seems that herpes simplex is now more often encountered.

Diagnostic problems often arise, and more so for physicians not familiar with it. This is especially true when the disease is rudimentary or just starting and also when it is very severe. Two cases of the first kind are reported.

Case Reports

Case No. 1. A white boy, was first seen at the age of 9 months with extensive atopic dermatitis. Under topical treatment with Colorado shale he made a quick recovery and, subsequently, had only occasional minor recurrences, which always responded quickly to Colorado shale oil, later in the form of Metashal® Ointment.

On May 14, 1956, at the age of 5 years, the boy was brought to the office because of an eruption in the genital area of three days' duration. Penis and part of the scrotum were swollen and studded with pustules and small circular crusts. There was a small eroded spot on the mucocutaneous junction of the right lower eyelid. Temperature was 99.8 degrees. There were no enlarged lymph nodes and the boy was only mildly ill. It was learned that he had been vaccinated 10 days ago (seven days before the breaking out), and the strong reaction was starting to dry.

Terramycin® Ointment and Elixir of Benadryl® were ordered. After three days, the eruption was practically gone. Atopic dermatitis on the scrotum was barely noticeable.

The Author

● Dr. Brandt, Cincinnati, is Assistant Attending Dermatologist, Cincinnati General Hospital; Director of Dermatological Service, Longview State Hospital, and Assistant Professor of Dermatology and Syphilology, University of Cincinnati College of Medicine.

On February 16, 1957 (after an interval of nine months) the boy was again seen in the office with a breaking-out of three days' duration. He presented a typical group of herpes simplex vesicles on his lower lip, and a few individual vesicles on his right shoulder, the dorsum of his left foot and, more numerous, on opposite areas of scrotum and left thigh. Temperature was 99.6 degrees and systemic reactions were mild.

The mother reported that as before the child had had occasional recurrences in patches, with the same quick therapeutic response. With Elixir of Benadryl in addition to talcum powder the herpetic lesions cleared within three days.

Case No. 2. A Negro boy, was first seen at the age of 2½ years. He presented eczematous lesions in ichthyotic skin, not typical of infantile eczema. There were, however, multiple food allergies and a positive family history.

Improvement was satisfactory but slow. Recurrences appeared and the eczema became more typical in appearance and distribution. Metashal Ointment was now applied and there was quick response except for one episode that lasted for almost two weeks. Thereafter, the boy was not seen for 15 months. From later reports by the mother it was learned that during that time he had shown only slight recurrences on his genitalia and that the previously prescribed treatment had always acted promptly.

On April 11, 1957, at the age of 5 years, the child was seen in the office because of a breaking-out of one day's

---

From the Department of Dermatology and Syphilology, University of Cincinnati College of Medicine, Cincinnati, Ohio.

duration. His prepuce was conspicuously swollen and there was paraphimosis. There were small nodular infiltrates in prepuce and skin of penis and scrotum, and the latter was studded with numerous crusts, obviously dried-up vesicles or, partly, pustules. Temperature was 100.4 degrees.

The picture was confusing, as no history of any possible contact could be elicited and development of a severe pyogenic infection had to be considered. However, a moderately strong vaccination reaction was present, 9 days old, which the mother had failed to mention in her excitement about the ominous looking genital affliction. Chlor-Trimeton® Compound orally and Meti-Derm® plus neomycin were prescribed and the swelling disappeared within 36 hours. After three days, only some roughness of the affected skin was left.

Discussion

The superimposed infection in the first child was vaccinia as well as herpes simplex 9 months apart. In the second child it was vaccinia. In spite of clinical differences between vaccinia and herpes simplex, varicelliform eruptions of both causes look very similar and the decision must be based on finding the source in the patient or his surroundings. Vaccinia infection can, of course, not recur after healing, but herpes can. I have seen it develop three times in a patient with extensive atopic dermatitis. Pyogenic superinfection may sometime suggest itself, but this usually develops in recognizable relation to scratching.

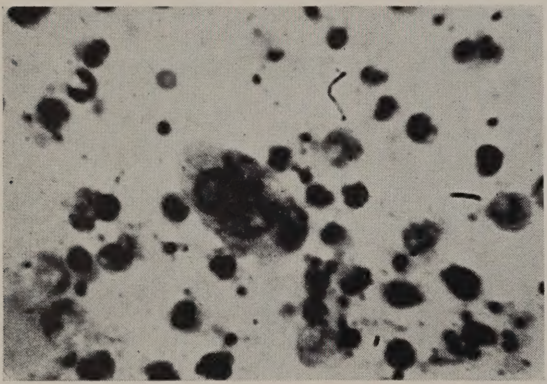

FIG. 1. Tzanck Test. Acantholytic prickle cells reveal the intraepidermal formation of the blister.

The atopic dermatitis that prepares the soil for the eruption need not be pronounced, as we saw in our cases. In this way, the infection may emphasize a minor residue, hardly noticed on fleeting observation. Conversely, the limitation to small areas demonstrates the degree to which healing has been achieved in other places. Rudimentary eruptions also point to an important diagnostic feature as against smallpox.

Smallpox is a systemic disease that involves the skin in its course. Varicelliform eruption is a skin disease that leads to systemic symptoms. Smallpox starts out with a severe systemic reaction, including fever. Shortly before the eruption appears, temperature drops and usually does not rise right along with the rash. Only when pustulation sets in, the temperature again becomes high.

In varicelliform eruption, there is only little systemic reaction, if or as long as the development is limited. The more severe picture, including high fever, unfolds itself with the spreading over large areas of skin. This course of events can be clearly followed, if one has the opportunity of seeing it start from the original herpes simplex on the patient or a member of the family. Once varicelliform eruption is fully developed, the temperature is mostly high (104 to 105 degrees) which, as long as the lesions are still vesicular, distinguishes the disease from smallpox in the comparable phase.

The expression "varicelliform" refers more to the development in crops or rather in stages than to the lesions themselves, which are often umbilicated and subsequently pustular and, therefore, might be termed "varioliform." When only seen at the peak, with both diseases pustular and highly febrile, varicelliform eruption indeed closely resembles variola. Laboratory tests are too slow for a decision on the spot.

Tzanck Test Helpful

There is one speedy test that may offer some help, but only for part of the problem. This is the Tzanck Test, which permits us to distinguish between subepidermal and intra-epidermal blisters, and is routinely done in our Department, for this purpose. The intra-epidermal blister forms through loss of cohesion between prickle cells, and scrapings from the floor of the blister (which consists of epidermis) reveal these elements. In the subepidermal blister the entire epidermis is lifted up; the floor consists of derma and no acantholytic cells are found in scrapings. This test may serve to demarcate pyoderma or erythema multiforme bullosum from varicelliform eruption (or smallpox), but since smallpox as well as herpes and vaccinia develop intra-epidermal blisters, the differential diagnosis within this group cannot rest on the Tzanck Test.

A thorough history, taking into account the points mentioned in the foregoing, especially including exposure to vaccinia or herpes simplex in the patient's surrounding, is of main importance.

Gingivitis and Systemic Disorders

The inter-relation between the health of the oral tissues and general systemic condition is so important that the dentist should not consider the treatment of the oral tissues as an independent subject.—Martin Cibien, D. D. S., Dearborn, Mich.: *Military Med.*, 122:408, June, 1958.

Antibiotic Combination Therapy of Severe Acne Vulgaris

A. P. R. JAMES, M.D.

THE prime consideration in severe pustular acne is the rapid elimination of infection. This will result in minimal psychological damage and prevent unsightly scarring. The older antibiotics are seldom of value. A preliminary study of this problem was undertaken to determine the relative value of two of the newer combinations:

I Alba-Penicillin*—contains 250 mg. Albamycin® Sodium (novobiocin sodium) plus 250,000 units of potassium penicillin G per capsule. (Patients were given one 5 mg. tablet of Delta-Cortef® (prednisolone) daily while taking Alba-Penicillin.)

II Panalba*—contains 250 mg. Panmycin® (tetracycline phosphate) and 125 mg. Albamycin Sodium per capsule.

The most satisfactory of these two combinations was Panalba. Alba-Penicillin while producing good results caused a high incidence of severe side reactions. These reactions could not be prevented by giving steroid therapy.

In this investigation it was interesting to note that 75 per cent of the patients who showed intolerance reacted to more than one antibiotic. In two of the cases the sensitivity as shown by patch tests and ingestion involved every new antibiotic tested. At the Central States Dermatological Meeting last year, in Pittsburgh, cross sensitization between neomycin and streptomycin was reported.[**1] Cross sensitization can be of great clinical significance since reactions to the various "mycins" can be serious. A history of intolerance to any one mycin may be of significance in the administration of another.

The therapist must bear in mind the fact that lesions due to infection are secondary. While treating the infection it is essential that the primary condition receive appropriate therapy.

No two cases of acne vulgaris are identical and of necessity therapy must be idividualized. However, it is possible to follow certain general procedures and apply them as indicated. *Diet* is a major factor. We forbid milk, chocolate, candy, pastry, cream, ice cream, cheese, nuts, carbonated water, and iodinized salt. We limit fat food, fried food, and butter. Proper elimination must be maintained. *Endocrine therapy* may be necessary. *Seborrhea* must be controlled. We suggest Fostex,® both for the scalp and to wash the affected parts. It is simple to use and has proved most effective. In all cases presenting pustules or other infected lesions, we attempt to raise the patient's resistance to staphylococci. We have found the most satisfactory results are obtained by giving National Staphylococcus *Toxoid* combined with Bacterial Vaccine. It is very important to give this preparation intradermally. X-ray and ultraviolet therapy are given as indicated. In addition, all patients receive vitamin B_{12} injections and take adequate amounts of water soluble U. S. Vitamin "A."

The Author

● **Dr. James, Toledo, is dermatologist to St. Vincent's, Mercy, Toledo, St. Luke's and Maumee Valley Hospitals; director, Department of Dermatology and Syphilology, City Clinics.**

Case Reports

In this investigation of the action of oral Panalba only severe cases were studied:

Case 1. A 21 year old male was first seen in our office on November 1, 1956. He presented very severe and extensive acne. He had been given many types of therapy including x-ray therapy to the limits of tolerance and had been hospitalized on several occasions by dermatologists.

He was started on our routine as outlined in the foregoing, including vaccine, erythema doses of quartz lamp, and given one capsule of Panalba twice daily. The medication was increased after one week to four capsules daily. After six weeks of therapy all the lesions had healed and the Panalba was discontinued. There has been no relapse and he has continued his other routine therapy. While he presents very extensive scarring he has had an excellent result.

Case 2. This boy was first seen, at the age of 16, in my office on November 19, 1954. He presented very severe acne conglobata of three years' duration. He was given routine therapy with little benefit. On July 9, 1955, Panalba, one capsule two times daily, was given in addition to his other therapy. The dosage was increased on September 24, 1955, to one capsule three times a day. He made slow but steady progress and was dismissed with all the lesions healed and no sign of any activity in the condition on January 15, 1956.

On February 13, 1957, the patient returned with a very severe and extensive recurrence. The face, neck, chest, back and upper arms were practically covered with cysts, ulcerated areas, pus, and scabs. The larger cystic lesions were incised. He was told to wash with pHisoHex® and given neomycin-polymyxin ointment to apply to the raw areas.

He was put on our routine therapy for acne and given

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*Trade name of The Upjohn Company.

[**1] Edwin Sidi, M. D.; Marc Hincky, M. D.; and Robert Longuevill, M. D.; all of Paris, France, have completed investigation studies and will publish report.

TABLE 1.—*Oral Panalba in Very Severe Cystic Acne*

No. of cases	Males	Females	Average			Side effects	Results
			Age	Weight	Duration of therapy		
72	31	41	23	142	36	Urticaria 2 Gastric upset 1 Mild transitory diarrhea 8	No value 4 Fair 9 Good 33 Excellent 26

TABLE 2.—*Panalba Topical*

No. of cases	Condition	Males	Females	Average		Side effects	Results
				Age	Duration of therapy		
106	Papulo Pustular Acne Vulgaris	56	50	20	8 weeks	2 Venenata	Excellent 85 Fair 19 No value 2
14	Impetigo	5	9	11	1 week	None	Satisfactory
6	Pyoderma	3	3	25	2 weeks	None	Satisfactory
15	Infectious Eczematoid Dermatitis	9	6	31	18 days	None	Satisfactory 9 Fair 4 No value 2

Panalba, one capsule two times a day. The condition showed only slight improvement and on April 13, 1957, the dosage was increased to four capsules daily. He continued on this regime for four weeks with no visible change. Then he suddenly started to respond. He gained 15 pounds in weight and he stopped developing new lesions. The older lesions rapidly regressed and after two more weeks of intensive therapy he finally presented an excellent response.

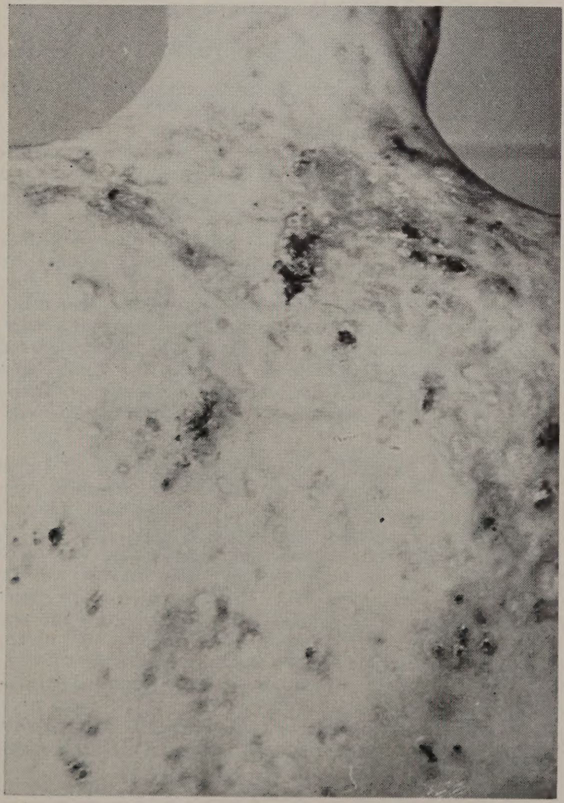

FIG. 1. Case No. 2: Patient photographed February 21, 1957.

Approximately 30 per cent of cases showed relapse after therapy was discontinued. These cases were returned to their original regime and in most instances the condition responded satisfactorily within a period not exceeding four weeks. It should also be noted that no case has suffered a second relapse to date.

Three cases of severe acne conglobata in our Panalba series were similar in all respects to a case treated with Alba-Penicillin in our original study. All four patients were boys whose trouble started about the age of 14. The mothers of these boys all gave a history of severe acne vulgaris and their faces were badly scarred. Extensive therapy had little effect prior to the use of Panalba. All four cases suffered severe relapse in about one year. When they responded to therapy the second time they did so suddenly and gained weight rapidly.

Panalba proved so effective it was decided to determine its status when applied topically. An evaluation of its tolerance, effectiveness and its sensitizing properties was taken.

The chart shows two cases of venenata. These two cases were patients from our original series who developed urticarial reactions to oral Panalba. Patch tests with placebo base were negative. These patients were sensitive to the topical antibiotic combination. However, the majority of patients were impressed with the results obtained and felt that the topical medication was of great value.

All investigators are cognizant of the potential sensitizing effect of topical applications of the newer antibiotics. Sixty-two patients who had applied this combination (Panalba) topically for a period of at least six weeks were given small amounts by mouth. Two cases developed mild

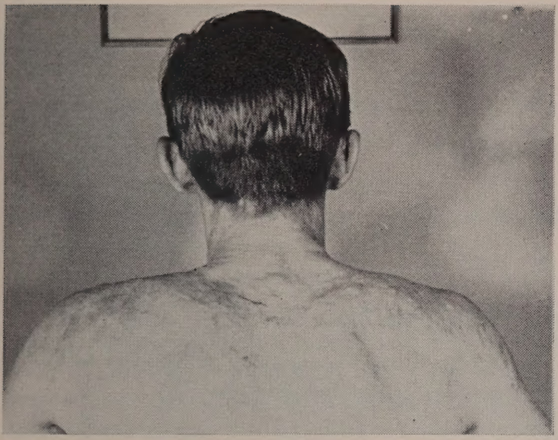

FIG. 2. Case No. 2: Photographed June 6, 1957.

urticaria which responded rapidly to steroid therapy. Unfortunately, we did not test these patients for oral sensitivity prior to the use of the ointment. This limited study would suggest that the incidence of systemic sensitization following topical use is slight.

Conclusions

Panalba in a dosage of *2 to 4 capsules daily* is of great value in the management of severe cystic acne. These patients must be given vaccine therapy and continue their other routine treatment for some time beyond improvement, in order to control relapse.

The topical use of this combination is well tolerated and produces very satisfactory results. It is of particular value in moderate cases of papulopustular acne vulgaris. Further investigative studies will be necessary in order to determine its sensitizing properties.

Pulmonary Hypertension Pain May Simulate Angina

The pain of pulmonary hypertension is worthy of consideration and this pain may mimic angina in almost every respect. While it may be precipitated by exertion or emotion, it may also occur at rest. In addition, the pain accompanying pulmonary hypertension is not dramatically benefited by Nitroglycerin. Often there is a generalized cyanosis.

Since the symptom is associated with increased pressure in the pulmonary circuit, a cause for this increase must be found. Such causes include mitral stenosis, atrial septal defects, patent ductus arteriosus, Eisenmenger's complex, disorders of the pulmonary artery and diffuse pulmonary diseases such as asthma, emphysema and bronchiectasis.—William J. Hand, M. D., Chicago: *Industrial Med. & Surg.*, 27:287, June, 1958.

Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEPFEL, M. D.
Columbus, Ohio, Chairman

Following is the summary of a case presenting, Associated Problems: "Papanicolaou Smear," which was discussed before the Franklin County Pelvic Cancer Delay Committee at its monthly meeting held on May 21st at the Columbus Health Center.

Case No. 61. The patient is a 32 year old white female who eight months prior to hospital admission had routine physical examination. Papanicolaou smear taken. Report received, "Atypical cells; request vaginal and cervical smears." Patient notified but failed to return until six months later because urgency not indicated. Papanicolaou smear again taken. Reported, "Atypical cells, recommend repeat Papanicolaou smear in three to six months."

Patient's physician felt more definitive action required and one and a half months later dilatation and curettage of uterus, and conization of cervix was carried out.

Diagnosis: "Infiltrating squamous cell carcinoma of the cervix, Clinical Stage I.

Impression: Institutional delay eight months. The delay in this case is directly referable to inconclusive interpretation of the Papanicolaou Smear Test report.

Comment: The Papanicolaou smear is a valuable agent for cancer detection. It must remain in our diagnostic procedures. Its misinterpretation constitutes a medical trap. With a report "atypical cells" this patient should have had an immediate biopsy of the cervix. Eight months ago we may have been dealing with a carcinoma in situ which would have required but a simple hysterectomy. Under the present circumstances irradiation and/or radical surgery in this 32 year old woman is indicated. In either event her ovarian tissue will be sacrificed.

Another trap is the "negative" report with the patient assuming that she is all right for a period of several years. A recall visit system must be part of office organization.

The pathologist should not recommend treatment but should clarify the reading of the slide. It is then the duty of the clinician to take the definite steps for other diagnostic procedures. Treatment should not be carried out on the basis of a Papanicolaou test. The pathologist needs a clean cut (cold knife) biopsy for adequate material on which to make a diagnosis.

Chlorpromazine Therapy

Chlorpromazine appears to be now established as a valuable pharmacological agent in the treatment of many medical conditions. Its use is widespread in hospitalized bed patients, as well as ambulatory patients. The drug has several side effects, the most serious of which is bone marrow depression with granulocytopenia.—Gunnar Vetne, M. D.: *J. Michigan M. Soc.*, 57:709, 1958.

Primary Carcinoma of the Lung

Clinicopathological Evaluation of Cases Seen at Autopsy St. Elizabeth Hospital, Youngstown, 1950-1956

ANGELO RIBERI, M. D.

FOR the past two decades increasing attention has been paid to the problem of primary carcinoma of the lung. It is of interest that, only fifty years ago, bronchiogenic carcinoma was considered to be almost a rarity and was infrequently incriminated as the cause of death in case history report.[1] However, in recent years, with the publication of numerous significant statistical reports, both in the United States and abroad, the once widely accepted opinion concerning the infrequency of bronchiogenic carcinoma has been dissipated.

Although we realize that the material presented herewith is not extensive enough to permit far-reaching conclusions, it has been of interest nevertheless to review the instances of bronchiogenic carcinoma found in the autopsy material studied at the St. Elizabeth Hospital. We have limited this review to the years 1950-1956, during which period 1,124 postmortem examinations were performed. Only primary carcinomas of the lung were included in this study.

Material

Among the 1,124 autopsies 31 cases of primary carcinoma of the lung were found, one of which was in a female, the other 30 in males. The youngest patient was 32 years of age and the oldest 83, with a mean average of 62 years. This figure compares favorably with those quoted by Crafoord[3], Wiklund[4], and Ochsner and associates.[5-7-8]

Terminal cachexia and emaciation were common findings in all patients, with the ultimate cause of death recorded as pneumonia, bronchopneumonia, pulmonary edema and acute passive congestion of the lungs. In one patient the immediate cause of death was attributed to duodenal hemorrhage and in another to perforation of a large gastric ulcer.

In one case obstruction and erosion of the superior vena cava had occurred. Superior vena cava syndrome due to occlusion of the superior vena cava is a fairly common complication of carcinoma of the right lung. It is easily recognized by the typical puffiness of the face and neck, bulging of the eyes and the development of a marked collateral venous circulation.

In another case a tumor of the right superior pulmonary sulcus was responsible for a typical "Pancoast's syndrome." In the past few years there has been some confusion about the proper designation of these tumors. Some writers have indiscriminately labelled them as "Pancoast's tumors." Since any tumor of the superior pulmonary sulcus, be it primary or metastatic, can give rise to symptoms of neurological involvement, it would seem more appropriate to call these tumors "apical tumors with a Pancoast's syndrome." Unfortunately, when superior vena caval occlusion and/or Pancoast's syndrome are present, the stage of operability has passed.

The Author

● **Dr. Riberi, Youngstown, is Resident in Surgery at St. Elizabeth Hospital.**

Twenty-one (64.4 per cent) of the tumors were of the epidermoid or squamous cell variety. Of these, two were of the anaplastic oat-cell type, two were anaplastic and two were multicentric. The remaining 10 tumors included a pleural endothelioma of the left lung, six adenocarcinomas, one mixed squamous and adenocarcinoma, an undifferentiated carcinoma and an anaplastic transitional cell carcinoma. The only female in this group was found to have an adenocarcinoma, which tumor is known to occur more frequently in females.

The smoking habits of these patients were not adequately investigated and therefore no conclusions relative to this problem can be drawn.

Invasion of the adjacent tissues and/or of the regional lymph nodes was the rule. Metastases were found in the mediastinal lymph nodes in 24 patients (77.4 per cent), in the adrenals in 13 cases, in the liver 11, and in the pleura nine. There was controlateral lung involvement in four cases while supraclavicular and aortic metastases were found three times, respectively. The spleen was involved twice, the epicardium, coronary arteries, left ventricle, right auricle, ribs, small bowel, prostate, vertebrae, pancreas, kidney, stomach and brain once. The incidence of one case with cerebral metastases is not very significant due to the fact that head examination was not carried out in every case.

The left lung was involved in 17 cases as compared to 14 in the right. This gives approximately 57 per cent left lung involvement and 43 per cent right.

In one instance there was recurrence of the neoplasm on the left side two years following pneumonectomy.

Metastases

Bronchiogenic carcinoma, like other carcinomas, metastasizes through the lymphatic and blood channels. However, in considering the paths of dissemination a bronchiogenic route should also be taken into account.

Many of the reports in the medical literature are based on autopsy material and frequently an incidence of metastases of almost 100 per cent is reported. However, occasionally low figures are reported. For example Miller and Jones[6] found metastases in only 30 per cent of a series of 808 cases. Ochsner, Dixon and De Bakey[7] who collected 3,047 autopsy cases from the literature, found the lymph nodes to be involved in 72 per cent of the cases. The liver was involved in 33.7 per cent with the other organ involvement to a lesser degree.

Ochsner and associates[8] in a recent report found mediastinal lymph node involvement in 80 per cent and pleuro-parietal involvement in 40 per cent of their cases.

In many series cerebral metastases have been found in as high as 30 per cent of the cases. This is easily understood when one appreciates the frequent involvement of the pulmonary veins by the growing tumor.

Discussion

Advances in thoracic surgery have made possible removal of carcinoma of the lung which were not considered amenable to surgery prior to 1933 and 1935 when the late Evarts Graham in St. Louis[2] and Clarence Crafoord[3] in Stockholm began to perform lung resections for bronchiogenic carcinoma. Surgical techniques have since improved steadily and more extensive and more difficult procedures are nowadays possible. However, the number of five year survivals is still very low due mainly to a late diagnosis as to the presence of early metastases in many cases when first seen.

In a series of 259 cases reported by Wiklund[4] of the Crafoord's Clinic, 91.1 per cent were men. He found the disease to occur mainly in patients over the age of 50. In his series the right lung was involved slightly more frequently than the left. In addition the lower and upper lobes were involved with equal frequency. The incidence of squamous cell carcinoma was 62.9 per cent. The most common primary symptom was, as in all our own cases, cough, the other usual primary symptoms being: the so-called "influenza," recurrent pneumonias and hemoptysis. One hundred of these 259 cases (38.6 per cent) were resected with 29 deaths in the immediate postoperative period. Thirty-three of the remaining patients survived three years after operation and 25 for more than five years.

In a recent statistical review, Ochsner and associates[8] reported on 1,360 patients with a clinical diagnosis of carcinoma of the lung seen at the Ochsner's Clinic between 1934 and 1956. Of these 442 were subjected to operation with only 33 per cent being found resectable. The tumor was found to affect the right lung in 54 per cent of the cases and the left lung in 46 per cent. Fifty-three per cent of the operated cases had an epidermoid carcinoma, 17 per cent an adenocarcinoma and 30 per cent an undifferentiated carcinoma.

The grave prognosis of the disease is readily appreciated when one considers that only 10 per cent of the Wiklund cases and only 8 per cent of the Ochsner cases survived for more than one year.

Conclusion

It is apparent from this study that early regional lymph node metastases are a very frequent finding in bronchiogenic carcinoma. This fact is a discouraging one, since, as demonstrated by this brief review of the literature, the five year survival rate after surgery is very low.

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Rehabilitation

Rehabilitation is the process of helping people live more effectively. This is a prime goal of modern dynamic psychiatry as well as physical medicine. While more specifically the focus of the former is on psychological factors and the latter on physical factors, neither specialty can be separated from the other as long as human behavior is involved.—Thomas F. Morrow, M. D., and Doris M. Rosenbaum, M. D., Wichita: *J. Kansas M. Soc.*, 59:215, May, 1958.

A New Technique for the Localization of Radiopaque Foreign Bodies

JOHN R. BROWN, M.D.

THE removal of a foreign body from soft tissues may be a very simple matter. However, finding this same foreign body can be a time consuming and traumatic task to both patient and physician. The first attempts at three dimensional localization were made by Shenton[1] who used multiple x-rays and calculated the depth of the foreign body. Willis[3] made more accurate localization possible in two planes by the use of a sterile metal screen in the operative field. Breck and Maylahn[4] in 1950, advocated exploration for the foreign body and placing a sterile clip in the wound. The foreign body was located in relation to this clip with x-rays.

For the past year we have used a technique which is simple and reduces operative time and trauma to a minimum. The hazard of burns from the use of the fluoroscope is completely eliminated. A review of the literature has not revealed the previous use of this technique.

Method

The foreign body is located grossly by anterior-posterior and lateral x-rays (Fig. 1). The area involved is shaved, washed, painted with an antiseptic solution and sterile drapes are applied. Under anesthesia two sterile No. 21 gauge needles of appropriate length are aimed at the foreign body (Fig. 2). One needle is placed perpendicular to the floor, the other parallel to the floor. Using sterile cassette holders, exactly vertical and horizontal films are taken with the portable x-ray machine. The films are viewed and if necessary the needles are placed again in an attempt to come closer to the foreign body (Fig. 3). This procedure is continued as long as necessary.

To date we have not had to replace the needles more than once in order to place the needle points virtually on the foreign body. The needles are left in place and an anatomical dissection carried down to the junction of their points. They can be palpated in the tissues without being moved so that the foreign body can be identified with marked ease and rapidity. As soon as the foreign body is removed the needles are withdrawn and the wound closed in the usual manner. It has not been necessary to drain any of these wounds.

Report of Cases

Case 1. The patient, age 31, was struck in the left thigh by a piece of metal on Oct. 11, 1955. Attempted removal under local anesthesia by his physician was not successful. The patient continued to have some discomfort with an area of numbness above the knee. Examination revealed a nontender movable linear scar 3cm. long. A 13 by 6 cm. area distal to the scar was completely anesthetic.

The Author

● Dr. Brown, Dayton, is Associate Attending surgeon at Good Samaritan, Miami Valley, and St. Elizabeth Hospital.

The foreign body was removed from the left thigh by using the two needle technique on April 12, 1956. The wound healed with no problem. When last seen one month following surgery the area of previous anesthesia had some return of sensation.

Case 2. A 37 year old white male. The patient was

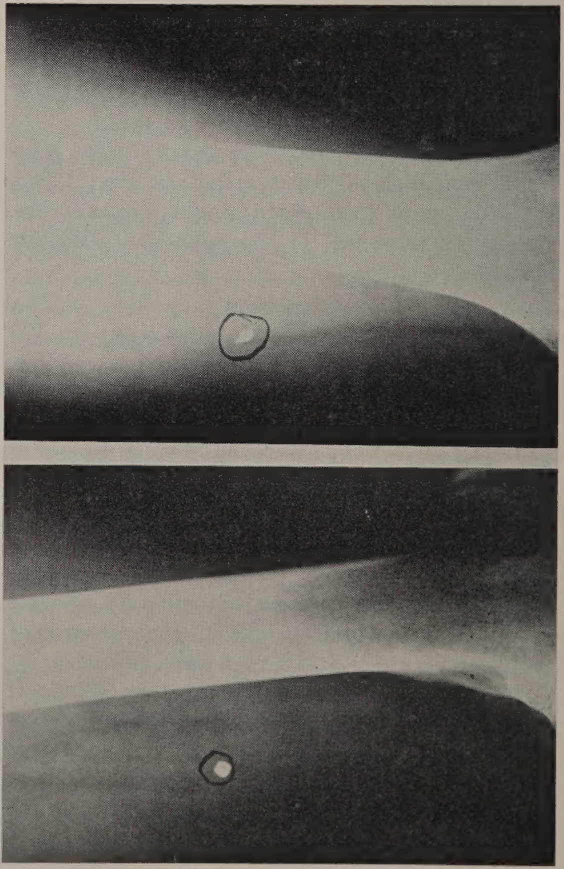

FIG. 1, A AND B. Antero-posterior and lateral films for gross localizaton of the foreign body.

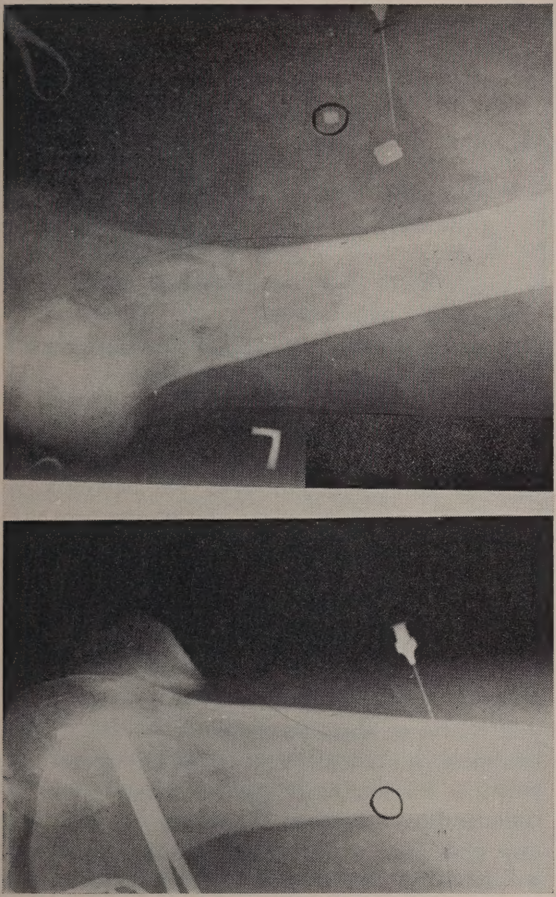

FIG. 2, A AND B. Needles have been placed under sterile technique for more accurate localization of the foreign body.

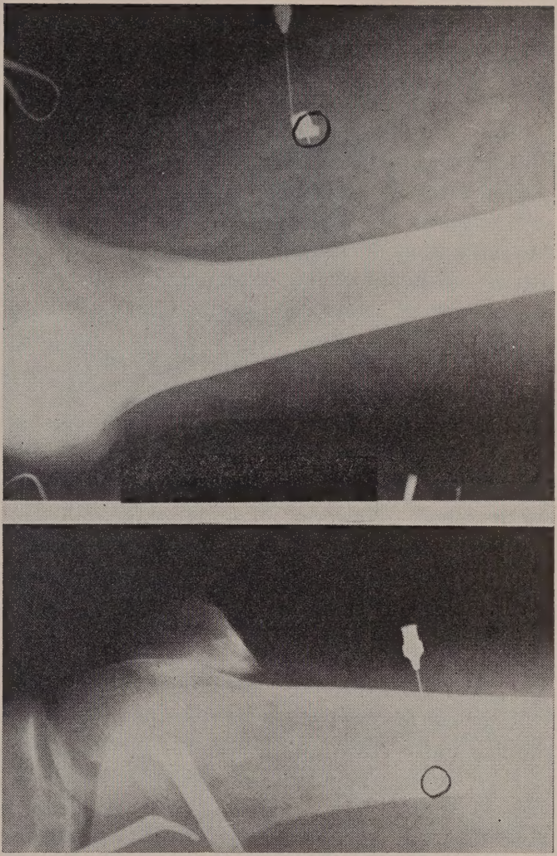

FIG. 3, A AND B. After replacement of the needles the foreign body can be located exactly.

struck in the left medial thigh on Nov. 22, 1956, by a piece of metal off a hammer. The wound healed but he continued to have acute pain distal to the wound on the anterior aspect of the lower thigh and knee with hypesthesia over the medial condyle of the femur. Peripheral pulses were normal.

On Dec. 13, 1956 the foreign body was found embedded in scar tissue in Hunter's Canal. Follow-up studies, one month later, revealed healing per priman with persistent anesthesia over the medial condyle of the femur. The two needle technique was especially helpful in this case. It eliminated the need for a full scale exploration of the saphenous nerve.

Discussion

The technique described above is of value when foreign bodies lie deep in soft tissue. It is particularly indicated when the foreign body lies near large nerves or vessels since it can reduce the risk of damage to these structures to an absolute minimum. If, by accident, the needle should be placed through a nerve of any size it is probable that no appreciable damage will occur. If major vessels are in the area, careful and slow placement of the needles with frequent observation is in order. If the hub of the needle pulsates with the heart beat it indicates the proximity of the point to the vessels and the needle can be re-directed or stopped at that point.

This technique is not applicable to the large body cavities unless the cavity is opened and solid and hollow organs are protected.

Summary

Radiopaque foreign bodies can be found most efficiently using two needles placed at right angles and serial x-rays taken at right angles. This technique cuts tissue trauma and operating time to a minimum.

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Carcinoma of the Lung

Carcinoma of the lung is a very common disease. It has been more common than carcinoma of the stomach since at least 1940.—Edward F. Parker, M. D., Charleston, S. C.: *J. South Carolina M. A.,* 54:207, June, 1958.

Postural Evaluation of Lower Chest Pain

CHARLES T. WEHBY, M. D.

THE prominence of heart disease and its attendant symptoms has made its presence, or absence, of vital concern to people today. Any indication of abnormality, usually brings the patient to the physician; especially, is this true, if any type of chest pain is encountered. This article deals with chest pain, which is caused by pressure from the abdominal organs, and particularly the splenic flexure of the colon.

This symptom complex is due to gas or spasm in the splenic flexure. This is not relieved by eructation, but the passing of flatus gives temporary relief. However, in some patients this is not possible, and the pain persists. This is the type of patient who consults the physician and his management is the basis of this essay, which deals with postural relief of diaphragmatic pain.

Anatomical Considerations

A review of the anatomy of the splenic flexure clarifies and corroborates its role in the causation of chest pain.. This structure lies cephalad more than any other portion of the colon. It is more fixed than the hepatic flexure and is in close relationship to the spleen, tail of the pancreas and left kidney. It is attached to the diaphragm opposite the tenth and eleventh ribs by a peritoneal fold, named the phrenicocolic ligament. This flexure is so acute that the end of the transverse colon usually lies in contact with the front of the descending colon. Any pathology of the splenic flexure will, due to its relatively fixed position, posteriorly, result in pressure against the adjacent organs noted above. Indeed I have noted a tympanitic quality to the percussion note over the left posterior chest below the scapular margin.

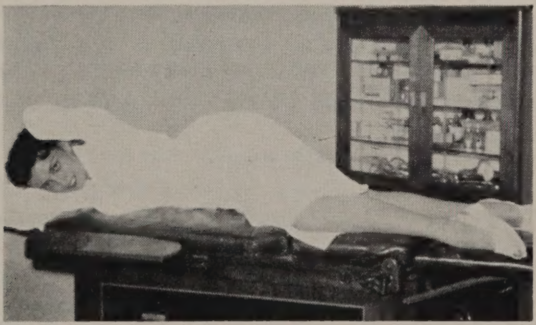

FIG. 1. Patient shown in position of maximum left diaphragmatic decompression.

With the individual in the erect or prone position the concavity of the diaphragm together with the encirclement of the lower thoracic cage and the tenseness of the abdominal muscles, the path of least resistance for the splenic flexure is against the dome of the diaphragm using the phrenicocolic ligament as a fulcrum. This causes a virtual tamponade of the diaphragm and may involve the phrenic nerve with resulting pain along its distribution. The role of the abdominal musculature is strengthened by the fact that this symptom complex is rarely seen in children or in patients presenting visceroptosis.

The Author

● Dr. Wehby, Cincinnati, is a member of the staffs of Good Samaritan Hospital and the Catherine Booth Home and Hospital.

It is evident, then, that individuals experiencing left chest pain and pain in the shoulder and arm will feel that the heart may be at fault and will consult their physician. These patients, if the pain is due to spasm or gas in the splenic flexure, will receive prompt relief if they are placed in the position shown in the accompanying picture (Fig. 1).

The patient lies on the right side with the hands placed behind the head. The face is directed laterally, and downward. The left leg is superimposed over the right and flexed at the knee. The left knee should touch the examining table. The right leg lies posteriorly and is also flexed at the knee. This position rotates the thorax, pelvis, and thoracolumbar spine forward and downward to their maximum degree, and allows the abdominal viscera to fall away from the left diaphragmatic area. It is, therefore, obvious that any symptoms due to mechanical pressure in this area, will be completely relieved or appreciably lessened.

By utilizing this technique, the physician should be able to clinically evaluate pain due to diaphragmatic pressure. I have found that it is a simple and valuable technique if properly used. No special equipment or complicated and time-consuming apparatus is required. It is hoped that the postural evaluation of lower chest pain, described in the foregoing, may add to the vast armamentarium already at our disposal for its differential diagnosis.

Treponemal Tests

Kahn, Nonreactive; V.D.R.L., Reactive; Kline, Weakly Reactive; Kolmer Wassermann, Reactive; Mazzini, Nonreactive

OLLIE M. GOODLOE, M. D., M. P. H., and LOUIS J. ROTH, M. D.

BEFORE the advent of the V.D.R.L. test only the Kahn test was given food handlers and patients at the Columbus Health Clinic. At that time we were averaging about 15,000 Kahn tests a year. Our average of positive tests on these food handlers was 6 per cent, or 900 cases. While the blood tests were being taken the food handlers were asked if they had ever had syphilis. Most of them denied having had the disease until a positive blood test came to light, and then admitted having had previous treatment.

Our smug reliance on the Kahn test was rudely disturbed when we started using the V.D.R.L. as a screen test. Much to our surprise, many of the food handlers who had negative Kahn tests showed positive V.D.R.L. tests. Immediate follow-up was done. A large majority of these food handlers with positive V.D.R.L. tests, who heretofore had shown negative Kahn tests, admitted having had previous treatment.

We now take blood tests on about 18,000 food handlers a year. The average still shows 6 per cent to have positive blood tests. Of these 1080 cases, 10 per cent were found to need treatment; 8 per cent of those who needed treatment had neurosyphilis. All these 1080 individuals were interviewed and examined. The great majority of them were diagnosed late latent syphilis. They were questioned about the amount of treatment they had had and when it was administered.

Methods of Treatment

If they were treated before 1944, we assumed that they were treated with Mapharsen® and bismuth. If a spinal test had been taken at that time, and was negative, and they had received a minimum of 10 Mapharsen and 20 bismuth, and showed no subjective or objective signs, no further treatment was advised. If no spinal test had been done at the time of previous treatment, one was now taken, and if this spinal test was negative no further treatment was given.

However, if the patient was irritable, had headaches, general aches and pains but no definite neurological signs, he was given 1,200,000 units of penicillin in oil twice a week for five injections even though the spinal test was negative. It has been very gratifying to find that about 70 per cent of these late latent patients who were treated showed great improvement in their headaches, general aches, irritability and general feeling of tiredness. This feeling of improvement cannot be altogether psychic because the effects of these injections are known to be long lasting.

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False Positive Determination

Many of the food handlers feel well, show no objective or subjective signs of syphilis, yet have a positive V.D.R.L. with a negative or a positive Kahn test. They give no history of having had treatment. In these doubtful cases, a battery test is taken which is sent to the Ohio Department of Health Laboratory. This battery test consists of a Kahn, Kolmer Wassermann, V.D.R.L., Kline, and Mazzini. A majority of these battery tests, however, are also indecisive—part of them being reactive, part weakly reactive and part negative.

These patients are questioned about colds, bronchitis, malaria, pneumonia, any long period of chills or fever, vaccinations, hepatitis and infectious mononucleosis. If there is a recent history of any of the foregoing, the blood test is repeated in three months. If at that time the tests become negative, the previous positive tests are assumed to have been false positives.

Specific Tests

If the battery tests are still indecisive, a Treponema pallidum immobilization (T.P.I.) test is done. In 10 months of 1956, 25 T.P.I. tests were

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Read before the Eighth Annual Health Commissioners Institute, Granville, Ohio, July 11, 1957.

taken; 20 cc. of blood was sent to the Ohio Department of Health Laboratory. Half of this was sent to the Venereal Disease Research Laboratory at Chamblee, Georgia, and the other half to the Ontario Department of Health Laboratory, Ontario, Canada. While 25 tests is a small sampling, 20 per cent of these showed complete agreement as to false positives; 40 per cent were in complete agreement as to true positives; 12 per cent were unsatisfactory in one or the other laboratory.

Thus we were again faced with the difficult task of determining whether 20 per cent of the 25 T.P.I. cases did or did not have syphilis. These patients were again interviewed; female patients, if parents, were advised to get blood tests on their children as well as their husbands; male patients, if married, were advised to have their wives tested. If these findings were negative and all other symptoms were negative, including the spinal test, we assumed that these cases were false positive.

Some of the questionable cases requested treatment after being informed of the doubtfulness of their syphilis.

Fallibility of All Tests

Our record of 20 per cent disagreement on the T.P.I. tests is due to the fact that the same blood was sent to two different laboratories. It would be informative to have a larger series done in this manner. While the T.P.I. test is more intricate than the spinal test, it is noteworthy that William T. Ford[1] and others gave an excellent demonstration on the degree of correlation that can be expected when identical specimens of spinal fluid are examined in two separate laboratories: 218 of the 264 cases of known neurosyphilis had positive spinal fluid. Of these 218 cases 72, or 33 per cent showed conflicting results.

In our evaluation of doubtful cases, we were influenced first by age. Most of these patients were above 35 years of age. A negative spinal fluid and no other symptoms persuaded us to give the patient the benefit of the doubt. In patients over 65 years of age, no spinal fluid specimen was taken since it is rare to find an active case of neurosyphilis above this age level. The second influencing factor in these questionable cases was Brusgaard's classic report of the fate of syphilitic patients who had received no specific therapy. Of his 473 cases, living or dead, who were examined, 64.8 per cent either died with no clinical or autopsy evidence of syphilis or were living from 3 to 40 years after infection, with no clinical evidence of the disease. This data was the result of a study made between 1889 and 1910 when syphilis was much more virulent than it is today.

One of the most difficult tasks is to try to convey to the patient who has had adequate treatment that while his blood remains positive he still does not have to worry about his syphilis. For this type of patient we have evolved a set of simple answers which the Ohio Department of Health will print and distribute to clinics.

Sensitivity of Specific Tests

Magnuson and Portnoy[2] report that "It is apparent that, in primary and secondary syphilis, the TPCF test is somewhat more reactive than the TPI test. In central nervous system syphilis, including tabes dorsalis, the TPI test was more reactive. In congenital syphilis, a slight advantage went to the TPCF test. In latent and cardiovascular syphilis, the two treponemal tests appeared to be about equally sensitive."

Portnoy[3] and Garson and Portnoy[4], in a series of 303 serums from patients with no clinical evidence of syphilis, but with positive blood tests, report the T.P.I. and the T.P.C.F. results showed 95.9 per cent agreement. In 61 serums submitted as definite biological false positives, the two tests agreed in 98.4 per cent. The T.P.C.F. test has the advantage of being slightly more sensitive, simpler, easier and quicker to carry out than the T.P.I. test.

The T.P.C.F. test gives promise of simplifying the task of arriving at a conclusive diagnosis.

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Thoracic Aortic Aneurysms Pose Serious Threat to Life

It is now well recognized that aneurysms of the aorta, whatever their location, pose a serious threat to life. The development of disabling symptoms and the probability of ultimate rupture are well known. The life expectancy for patients with syphilitic aneurysms of the thoracic aorta has been estimated to be six to nine months. Similar statistics for thoracic aneurysms of other varieties are not available but it is likely that thoracic aneurysms of arteriosclerotic, traumatic or congenital origin also carry a poor prognosis.—F. Henry Ellis, Jr., M. D., Rochester, Minn.: *Minnesota Med.*, 41:335, May, 1958.

Clinical Evaluation of Two Recently Developed Urographic Media

J. N. TAYLOR, M.D., and K. W. GENTERS, M.D.

IT IS the purpose of this paper to report our findings on two recently developed intravenous urographic media. In our clinic Diodrast® was abandoned over 10 years ago because of occasional severe side reactions. Neo-Iopax® was used until Urokon® became available. We felt that Urokon afforded a higher percentage of diagnostic films. Our dissatisfaction with this compound was largely due to the high incidence of nausea and vomiting.

Seeking a more satisfactory radiographic medium, we began to employ both Hypaque® and Miokon.® It then was our clinical impression that these media each afforded consistently as good diagnostic urograms as did Urokon. Furthermore, there seemed to be a definitely smaller number of untoward reactions. This study was then carried out to compare these two media, Hypaque and Miokon, to confirm our clinical impression and also to determine statistically if one drug was superior to the other.

Technical Data

Hypaque is a sodium 3,5-diacetamido-2,4,6-triiodobenzoate which contains 59.87 per cent iodine. It is injected intravenously as a 50 per cent solution. Miokon* is a sodium 5,5-dipropionylamino-2,4,6-triiodobenzoate which contains 57.3 per cent iodine. It too is injected as a 50 per cent solution.

One thousand patients undergoing intravenous pyelography were used in this study. Miokon was administered to 500 of them and Hypaque to the other 500. The patients were unselected and had no preparation prior to the injection of the dye.

TABLE 1.—*Comparative Quality of Excretory Urograms.*

Grade	Miokon Number	Miokon Percentage	Hypaque Number	Hypaque Percentage
Excellent	230	46.0%	209	41.8%
Good	172	34.4%	179	35.8%
Fair Poor } Unsatisfactory	98	19.6%	112	22.4%
Total	500	100%	500	100%

From each patient a careful history was obtained concerning allergies such as asthma, hay fever and drug sensitivity.

Selection of the contrast material in each case was picked at random by the nurse and administered by a physician who had no knowledge as to which one was being used. After a scout film was taken, 30 cc. of the contrast material to be used was injected intravenously over a period of two to three minutes. Subsequent films were taken, five, 10, and 15 minutes after the administration of the contrast media. Side reactions were recorded as noted.

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The films were graded as excellent, good, fair and poor. The films graded as excellent and good were considered satisfactory to establish a diagnosis, while the films graded as fair and poor did not permit accurate diagnosis.

Results

As shown in Table 1, 500 urograms were obtained with each contrast medium. With Miokon, diagnostic films were obtained in 80.4 per cent with 46.0 per cent of them being excellent and 34.4 per cent good. With Hypaque, diagnostic films were obtained in 77.6 per cent patients with 41.8 per cent of them being excellent and 35.8 per cent good. Unsatisfactory results with Miokon were present in 19.6 per cent as compared to 22.4 per cent with Hypaque.

Reactions

The number and types of reactions are shown in Table 2. Out of 500 patients who were given Miokon, we encountered 48 (9.6 per cent) reactions, while there were 14 (2.8 per cent) out of the same number who received Hypaque. All but two of these reactions were minor and required no treatment. In one case, after injection, hives and difficulty in swallowing occurred. This was thought to be due to pharyngeal edema which was relieved immediately after the intravenous administration of 50 mg. of Benadryl® Hydrochloride. Another patient developed hypotension after the dye was given. Although this reaction should be grouped under the more severe ones, the patient recovered before any treatment could be started.

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*We are indebted to the Mallinckrodt Chemical Works, St. Louis, Mo., for supplying us with Miokon for this study.

In those patients in this study with a definite history of allergy, the incidence of reactions was higher. Of the 500 patients in the Miokon series, 84 gave a history of allergy and 15 (17.8 per cent) of this group showed side reactions. In the remaining 416 patients who gave no past history of allergy, 33 (7.7 per cent) showed undesirable side reactions. With Hypaque the incidence of side reactions in 58 patients with a positive allergy history was 6.9 per cent as compared with 2.2 per cent of the patients who gave no such history. (Table 3.)

TABLE 2.—*Number and Type of Reactions.*

	Miokon	Hypaque
Nausea and vomiting	10	6
Nausea only	13	0
Itch	2	0
Bitter taste	7	2
Hives	8	3
Sneezing	0	1
Hypotension	1	0
Hives and pharyngeal edema	1	0
Chills	0	2
Flushes	5	0
Dizziness	1	0
Total	48 (9.6%)	14 (2.8%

TABLE 3.—*Correlation of Reactions with Allergy History.*

	Number of patients with Miokon	Hypaque
History of allergy	84	58
Reactions Patients with allergy	15 (17.8%)	4 (6.9%)
Reactions Patient without allergy	33 (7.7%)	10 (2.2%)

Discussion

Nicolai[1] in a study with Miokon in 750 patients reported only 30 cases, or 4 per cent, with unsatisfactory urograms. Speicher[2] using Hypaque, considered 15.2 per cent of his series as nondiagnostic. In a comparative study of four different contrast media evaluated by Lentino[3] 80 per cent of the urograms obtained with Hypaque were diagnostic and 20 per cent were unsatisfactory. This discrepancy, as regards the percentage of diagnostic films in our series as compared to those just mentioned, is probably due to the fact that the reading of the films is a subjective evaluation. This has been emphasized by Lentino[3] who has pointed out that such studies should always be comparative ones to minimize this factor. Our higher percentage of unsatisfactory results may be due to the fact that our patients received no special preparation prior to intravenous urography.

Compared with other series, our percentage of reactions was rather low. Speicher[2] in his Hypaque study reported 10.4 per cent side effects in 800 patients. These included nausea, vomiting, urticarial reactions. allergic rhinitis, faintness and transitory hypotension. Lentino[3] again with Hypaque noticed the same variety of reactions in his patients; however, the incidence was even greater, being 17 per cent.

The number of side effects in the preliminary report on Miokon by Nicolai[1] coincides with our own figures. Out of their 750 patients, 9.8 per cent experienced one or more reactions. The incidence of reactions is significantly higher in our series in those patients who gave a definite history of allergy. This stresses the importance of obtaining such a history prior to the administration of these compounds.

Lentino[3] has shown that skin and ocular tests with the urographic media to be used are of little value. He believed only reactions following the administration of an intravenous test dose are of significance. We agree and employed this method of testing during the last half of our study. The whole amount of contrast medium to be given is drawn up in a syringe and the injection started with 1 cc. If, after an interval of two to three minutes, the patient does not show any untoward reaction, the remainder of the dye is given within two to three minutes. Should the patient show some kind of side effects, the injection is discontinued. Although we did not encounter any severe reactions during the second half of our study, we feel more safe employing this procedure and hope to minimize the chance of being faced with a serious side reaction.

Summary

Two new intravenous urographic media, Hypaque and Miokon, were tested equally in 1000 patients.

Both Hypaque and Miokon were of equal value in visualizing the urinary tract.

With Miokon, a higher incidence of side reactions was noted.

In patients who gave a history of allergy, the incidence of side effects was higher than in those without such a history.

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Chronic Simple Glaucoma

A Case Report on Preventable Blindness

WILLIAM H. HAVENER, M. D.

A BLIND EYE is a serious loss to both patient and community. Awareness of the preventable nature of a significant portion of this blindness should help in reducing the incidence of such tragedies. The representative cases to be presented here are selected to emphasize relatively common causes of blindness which can in many instances be averted by proper, timely care.

Case Report

Three years prior to medical consultation this 49 year old woman suffered a "whiplash" neck injury in an automobile accident. Because of persistent cervical pain, she was treated by a chiropractor. During the subsequent three years she had frequent headaches on the occipital region and noted gradual marked visual loss in the right eye. Optometric consultation confirmed visual disease with an associated upper central visual field defect. The optometrist concluded the automobile injury was responsible, advised continuing cervical manipulations, and prescribed a series of glasses to relieve "eyestrain."

She was finally referred to a neurosurgeon who immediately recognized pallor of *both* optic discs, associated with the typical deep "cupping" of glaucoma. (Glaucomatous cupping begins at the rim of the disc in contrast to the central depression of a physiologic cup which has intervening normal tissue between the cup and the disc edge.) Visual acuity was reduced to 20/100 O. D. and 20/30 OS. Tonometer tension was over 50 mm. of mercury in each eye.

Therapy with pilocarpine drops restored intraocular pressure to normal levels in the low 20's and immediately relieved her headaches. Unfortunately there can be no restoration of her lost visual field and acuity, though further loss will be prevented.

Discussion

Chronic simple glaucoma has aptly been termed "the thief in the night" because without warning it gradually and irreversibly destroys vision. It is usually asymptomatic until far advanced, and therefore discovery of chronic glaucoma is *too late* when made through the patient's complaints. Early diagnosis and preservation of vision is possible only by routine screening examinations. Glaucoma should be suspected under the following circumstances.

(1) If the patient is over 40 years of age—(2 per cent of patients over 40 have glaucoma).

(2) If there is a family history of serious visual loss (glaucoma is hereditary).

(3) If the corneal diameter is 10 mm. or less (average normal is 12 mm.).

(4) If the anterior chamber is shallow and the iris seems to bow forward toward the cornea.

(5) If the frequent, unsatisfactory changing of glasses suggests the possibility of disease.

(6) If there is unexplained aching about the eyes.

The Author

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Coexistence of age over 40 years and any other one of the above listed factors should strongly suggest the desirability of referral to an ophthalmologist. Tonometric measurement of intraocular tension is required for accurate diagnosis. This is done routinely by ophthalmologists in the examination of elderly patients. The intraocular pressure in chronic simple glaucoma is usually not elevated enough to permit detection by finger tension. Finger tension is easily confused with compressibility of orbital tissues, and even when done by an expert may be in error by as much as 10 mm. of mercury.

Tonometry is a simple screening procedure which is readily performed under topical anesthesia (as with Pontocaine® 0.5 per cent). Because of certain contraindications such as the presence of eye infection or diseased corneal epithelium, tonometry should be done only after receiving instruction in technique from an ophthalmologist. Normal tension at one reading does not guarantee absence of glaucoma. Tensions elevated above 27 mm. of mercury require further evaluation by a variety of tests.

It is regrettable that the textbook emphasis on glaucoma suggests it should be detected by findings such as the following:

(1) Reduced visual acuity uncorrectable with glasses.

(2) Visual field losses.

(3) Cupping and atrophy of the disc as recognized by the ophthalmoscope.

Undeniably the diagnosis can be made under these circumstances, but it is TOO LATE! Such a patient will already have sustained severe and irreversible eye damage. For maximum benefit to the patient, chronic simple glaucoma must be discovered by suspicion of the disease in the over-40 group. Confirmation of the early diagnosis is possible only through tonometry.

With great frequency both ocular and systemic diseases manifest themselves through visual disturbances and eye fatigue. The patient has no way to differentiate these symptoms from those of refractive error. Should he seek aid from a nonmedical refractionist, diagnosis of the true nature of his difficulty and proper treatment are often considerably delayed.

One final comment is pertinent. If glaucoma were a disease which could not be modified by treatment, early diagnosis would be of little avail. The great majority of early cases do respond well to proper use of miotic therapy. By contrast, advanced cases often fail to be controlled by medical or surgical means, and account for 12 per cent of all blindness in the United States.

Relationship of Hyperglycemia To Arteriosclerosis

Our observations suggest that there is a relationship between the frequency of the occurrence of high glucose tolerance curves and the various clinical and laboratory data in our series of cases which may be considered as stigma of arteriosclerosis. The relationship of hyperglycemia to arteriosclerosis is not clear. Whether the hyperglycemia here observed is the manifestation of a true diabetes is questionable. Duncan states that arteriosclerosis per se is not a cause of diabetes. He reasons that if it were, the incidence of diabetes would not be decreasing during the phase of life in which arteriosclerosis is on the increase. However, a hyperglycemic tendency may favor the occurrence or accelerate the degree of artriosclerosis as is the case in true diabetes.

The cause of hyperglycemia in hypertension and arteriosclerosis is not known. O'Hare suggested arteriosclerosis of the arteries of the pancreas as the cause, but Joslin *et al.* found marked arteriosclerosis of the pancreatic arteries in only 23 of 484 autopsies and concluded that arteriosclerosis as a factor in the etiology of diabetes is hardly of great significance.

Goldring and Chasis found that coronary insufficiency occurs more frequently among hypertensives than among nonhypertensives of same age group. Bradley also stated that it is an accepted fact that arteriosclerosis is more common in hypertensives than in normotensives of the same age.—Joseph Weinstein, M. D., and Isidore Stein, M. D., Brooklyn: *New York State J. Med.,* 58: 1857, June 1, 1958.

Selective Readings

The Doctor His Patient and the Illness, by Michael Balint, M. D., with a Foreword by Maurice Levine, M. D. ($7.50, *International University Press, New York 11, N. Y.)* The appearance of an American edition of this text is an event of importance for all workers in medicine. It is a serious consideration of fundamental research on the function, the practice of the personal physician. The book takes as its point of departure some of the basic premises of the current thinking in this field—that the personal physician must deal with problems that are in some ways quite different from those of the hospital physician—that medical work must be concerned with more than diseases and with more than the form and function of individual organs—that much of the medical practice has to do with *patients* as *persons,* their emotions, their response to illness and the like—that psychiatry has now developed enough understanding of human dynamics and interpersonal relations so that it may have something to contribute to the general practice of medicine and, finally, that the time has come for something more solid than admonitions and advice to pay attention to social and psychological factors.

The book presents a discussion of the series of weekly seminars which were the basis of a long-term approach and training project. In these seminars a psychiatrist and a group of general practitioners tried to face the actual facts of medical practice and studied the practitioners' problems, their difficulties and their successes. As our own professor of Psychiatry at Cincinnati says, "this is a searching and stimulating volume on one of the most urgent problems in the practice of medicine on the ways in which the doctor can use himself as one of the major tools in his therapeutic armamentarium."

Economic Institutions and Human Welfare, by John Maurice Clark. ($4.00, *Alfred A. Knopf, Inc., New York 22, N. Y.)* The former president of the American Economic Association and the recipient of many honors in the field has written a vigorous and incisive book on one of the major problems of the modern world. The problem is the relation between economic life in the country and the general welfare of the citizens. This volume explores the myriad ways in which the seemingly narrow technical problems of economics and the vital influence on human achievement and happiness probes deeply into the nature of freedom, into the relation of science to value, analyzes the fallacies of extreme freedom that lead to inhumanity and of extreme control that lead to despotism.

MATERNAL HEALTH IN OHIO

TOPIC THIS MONTH:

Maternal Deaths* Involving Liver Disease

Case No. 41

The patient was a 20 year old Negro, Para I, who died four days and five hours after delivery at term. Her past history was not remarkable. Last menstrual period was September 20. From third month of gestation till term, antepartum history was followed in the dispensary with adequate care. The only abnormalities found during this time were a 1 plus albuminuria in the third month, which cleared spontaneously and a 1 plus ankle edema, which cleared over a two week period in patient's eighth month of pregnancy; both responded well to ammonium chloride and phenobarbital. Her total weight gain was 26½ pounds and the blood pressure was never higher than 124/75. Hemoglobin, 10.9 grams; serologic tests for syphilis, negative; pelvimetry during eighth month revealed a normal fetus, left occipitoposterior (L.O.P.), and adequate room for delivery below.

At term (June 20) the patient was admitted to the hospital in labor with pains every eight minutes and passage of a small number of clots. Blood pressure, 164/90; 1 plus albuminuria, and a 1 plus edema. The membranes were ruptured artificially and meconium stained fluid was observed. When the cervix was 5 cm. dilated, the fetal heart sounds were good and the patient's blood was typed and cross-matched.

The patient was medicated at 1:15 a. m. with 100 mg. of Demerol®, Seconal®, and scopolamine gr. 1/200. The Demerol 100 mg. and Seconal 50 mg. was repeated 45 minutes later. There was rapid progress and the patient was taken to the delivery room three hours and 20 minutes after labor began. A spinal anesthetic (procaine 50 mg.) was given, and a 7 pound, 4 ounce, child was delivered stillborn by Kjielland midforceps (L.O.P.) over an episiotomy at 3:00 a. m. The placenta separated spontaneously and repair of lacerations of the cervix, vagina, and episiotomy were accomplished.

As patient was being transferred from the delivery table, she fell on the floor, landing on her left hip. Blood pressure, 120/70, respirations good, and pupils reacted to light and accommodation. At this time the patient was deeply narcotized. A medical consultant's opinion was that the patient was over-sedated and post-spinal status. A neurosurgical consultant's opinion was moderate shock from blood loss and narcosis.

At 8 a. m., 9:50 a. m., 1 p. m. and 3 p. m. the patient received one unit of blood with much improvement of her general condition in the following 24 hours. The blood pressure rose to 160/90, but with 0.5 grain of phenobarbital the patient became stuporous and developed hematemesis with the rising blood pressure. Blood chemistry revealed a marked liver damage, treated with intravenous glucose, glutaminate and vitamins, but the patient pursued a downhill course and died on the fourth day. Autopsy was permitted.

Cause of Death: The clinical impression was acute yellow atrophy of the liver with uremia, toxic hepatitis, and pre-eclampsia.

Pathological Diagnosis: (1) Acute hepatitis. (2) Lower nephron nephrosis.

Comment

This case provoked great interest and numerous questions by members of the Committee; however, members felt hampered by a lack of laboratory findings, and details relative to the second stage of labor. The Committee felt the toxemia should have been treated vigorously on admission. Further, the Committee questioned the use of Kjielland forceps, and delivery of fetal head as an L.O.P.; was it midforceps? With no mention of specific blood loss, but repair of cervix, vagina and episiotomy, it was assumed *accouchement forcé* was attempted. The four units of blood, it would seem, contributed to her lower nephron nephrosis, although anuria was not mentioned. The Committee voted this a preventable maternal death.

Case No. 43

This patient was a 40 year old, white primigravida, who died undelivered in her seventh month. Her past history revealed cirrhosis at eight years, and later, in 1946, a surgical biopsy of the liver. This confirmed a diagnosis of cirrhosis. Six years later she received transfusions for gastrointestinal bleeding; and her hospital admission (date unknown) was for a similar cause. Her last menstrual period was December 12, but she registered in her fifth month of gestation, May 26; blood pressure 126/70 and weight 145 pounds (normal 136).

On June 20 the patient was seen at home by her (internist) physician because of sudden weight gain. She was admitted to the hospital June 22, pale, weight 165 pounds, blood pressure 120/80, ankle edema, and no fetal heart tones. Laboratory studies revealed 4 plus

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*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by official representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

albuminuria, hematocrit 28 per cent, chlorides 590 mg. per 100 cc., total protein 4 mg., albumin 2.34 mg., globulin 1.6 mg., uric acid 3.8, and urea 35.

Six days later under intensive therapy the patient was improved. There was still a 2 plus albuminuria, and her weight was 168 pounds. The urinary output was good, and a transfusion was given.

On June 27 at 1:50 a. m. the patient vomited blood, her condition became critical suddenly, and a transfusion was started; oxygen was administered. At 2:50 a. m. she developed rectal incontinence with massive hemorrhage and she died at 3:00 a. m. while receiving the second unit of blood. Autopsy was permitted.

Cause of Death: Exsanguination due to rupture, esophageal varices; cirrhosis of liver, Laennec's.

Pathological Diagnosis: Cor pulmonale; portal cirrhosis; arteriolar nephrosclerosis; bilateral pulmonary atelectasis and edema; pregnant uterus, postmorten cesarean section at seven months, stillborn male fetus.

Comment

From facts in this case it appeared the patient should have sought care earlier in view of a history of liver disease. Also, in view of this, she should have been hospitalized for liver function studies in the fifth month. Considering facts available in the case, the Committee voted this a nonpreventable maternal death.

Case No. 44

This patient was a 26 year old, white, primigravida, who died undelivered in her thirty-fifth week of gestation. Her past history was not remarkable. With a last menstrual period October 22, she registered with her physician in her seventeenth week. Physical examination revealed only an asymptomatic mitral systolic murmur. Serologic tests for syphilis negative; blood A-negative. She had five prenatal visits; her course was uneventful until her thirty-third week.

On June 12, (at 33 weeks), the patient was admitted to the hospital with chills and fever of four days' duration, frequency, dysuria, dyspnea of one day's duration, and lower abdominal tenderness; no gastrointestinal symptoms. Physical examination revealed a temperature of 102.2°, pluse 88, respirations 16, and blood pressure 130/80; 2 plus edema of the lower extremities, fundus 3 cm. above umbilicus, fetal heart tones 150 in left lower quadrant. She had generalized uterine tenderness in the right, costovertebral angle tenderness, paronychia of the left index finger. Hospital Course: *Urological consultant:* Toxemia and pyohydronephrosis; *Obstetrics and Gynecology consultant:* Pre-eclampsia and pyelonephritis. She was placed on antibiotics, intravenous fluids and Thorazine® for nausea, 105 mg. in four days, and intravenous vitamins.

June 12. Hemoglobin 13.2 Gm., red blood cell count 4.25 million, white blood cell count 9,200. Urine: albumin 20 mg., white blood cells 0, blood urea nitrogen 39.3, uric acid 12.0 mg.

June 14-19. The patient developed jaundice, melena and fever. The blood urea nitrogen was elevated, CO_2 decreased, cephalin flocculation and bilirubin increased, renal output diminished. Therapy included nasal oxygen.

June 20. Deeply jaundiced, comatose, severely dyspneic. Intake 2,500 cc. Output 185 cc. Temperature 99.6°; pulse 120; respirations 30.

June 21. Almost complete coma; temperature up to 103.°. No fetal heart tones heard. The patient expired at 1:30 a. m. June 22. Autopsy was permitted.

Pathological Diagnosis: Subacute yellow atrophy of liver; enteric hemorrhage, massive; mucosal enteric hemorrhage; pulmonary edema and congestion; aspiration of gastric contents; toxic myocarditis, slight; cardiac hypertrophy, slight; toxic splenitis; toxic nephrosis, slight; intra-uterine pregnancy, 8 months (postmortem stillborn, 38 weeks); icterus, marked.

Comment

This case was voted a nonpreventable maternal death. The Committee was particularly interested in the course of events in this case which apparently began with urological complication, and a mild toxemia. Following the administration of Thorazine (in accepted dosage) signs of liver damage developed, and the patient pursued a downhill course, to death, with renal failure.

Comment of Consultant

The following comment of a consultant, who is a specialist in Internal Medicine, was given at the request of the Committee.

Fortunately, liver disease as a contributing factor to maternal mortality is a rather rare occurrence. The three cases presented are of unusual interest in that two present with acute liver damage and one with the pregnancy complicating a case of chronic liver disease. In our experience significant chronic disease of the liver, such as is seen in portal cirrhosis, is not often associated with pregnancy. There seems to be enough endocrine disturbances present in these individuals to make conception and delivery a rather unusual happening. However, because of the numerous diagnostic procedures and the frequent use of blood or blood products associated with care during pregnancy, it is amazing that we do not see more acute liver disease.

Homologous serum hepatitis may be readily transmitted through contaminated instruments, needles, blood, or blood products. Since all of these are used liberally during the prenatal and postpartum periods, it would seem to me that the incidence of liver disease will gradually increase in this group of patients. Unfortunately, we have no good method of management of this complication, having to rely almost exclusively on supportive therapy. It is mandatory for anyone making use of these instruments or products to be extremely careful that sterilization procedures are adequate to prevent the transmission of this form of liver disease.

One other form of liver disease that is rather rare at the present time is that associated with eclampsia. The incidence of this complication has dropped since the institution of better prenatal care.

One should also bear in mind that acute liver disease may be associated with the use of some of the new tranquilizing and anti-emetic drugs available at the present time.

It is my feeling that the liver disease itself was not curable in the individuals mentioned and that none of these should be listed as preventable maternal mortality.

A Clinicopathological Conference

Edited Under the Auspices of the Ohio Society of Pathologists

WILLIAM SINCLAIR, M. D., *President*

Presentation of Case

THIS 56 year old white male was first admitted to University Hospital, Columbus, Ohio, 23 months before his death. His chief complaints at that time were abdominal swelling of six months' duration, a weight loss of 25 to 30 pounds, and exertional dyspnea of gradual onset. He had also suffered from paroxysmal nocturnal dyspnea and orthopnea over a six month period. He had been treated with digitalis and diuretics without much improvement and had had seven abdominal paracenteses. Four months prior to University Hospital admission he apparently had an illness labled S. aureus spinal meningitis and was a patient in another Columbus hospital. He had been on heavy alcohol intake for many years; his family history was noncontributory.

Physical Examination

Physical examination showed a malnourished, chronically ill white male in no apparent acute distress. His blood pressure was 108 over 64. Auscultation of the heart revealed a grade 3 rough low-pitched systolic murmur at the apex associated with an apical systolic thrill. There was also a grade 2 high-pitched blowing pandiastolic murmur radiating from the aortic area, and the first mitral tone was loud and snapping. A prominent third heart sound was heard in diastole. The abdomen was distended and showed flank dullness and a fluid thrill. There was slight pitting edema of both lower legs.

All laboratory tests were normal except for a reversed albumin/globulin ratio, an increased thymol turbidity and an alkaline phosphatase of 11.1 units. The ascitic fluid showed a specific gravity of 1.012 and was sterile. Six blood cultures were negative. Two stool guaiac tests were negative and two were positive. X-ray studies showed only an enlargement of the left atrium. The electrocardiogram showed atrial fibrillation and digitalis effect. The patient was afebrile throughout his 15-day hospital stay. He was maintained on digitalis and showed a poor response to mercurials. He had two abdominal paracenteses. He was discharged to continue on digitalis, vitamins and a low sodium diet.

Presented by

- **Norman O. Rothermich, M. D., Columbus, and**
- **Emmerich von Haam, M. D., Columbus. Edited by Dr. von Haam.**

Second to Ninth Admissions

In the following 20 months the patient was admitted eight times for complaints of increasing edema and ascites, periods of anorexia, and two bouts of diarrhea. He also had periods of tarry stools and intermittent brief bouts of hemoptysis. On his eighth admission he developed a phlebitis of his right leg and ecchymoses over both limbs. His physical examination showed varying degrees of ascites and pedal edema with accentuation of the edema during his bout of phlebitis. His heart murmurs persisted; his liver size varied and at times was found normal.

Numerous x-ray pictures taken during this period showed a steady increase in his heart size, varicose veins of his esophagus, a scarred duodenal bulb, and a nonfunctioning gallbladder. Laboratory studies during these admissions showed persistently negative blood cultures, intermittently positive tests for occult melena, varying levels in his plasma proteins and rather inconclusive tests for liver function. However, a liver biopsy taken during his fourth admission showed no liver pathologic condition. A hepatic wedge pressure taken at the same time showed normal pressure. The patient was tapped on four occasions. He remained afebrile and was discharged to be followed as an outpatient in the Cardiac Clinic.

Tenth Admission

The final admission came three weeks following his last discharge. In the interim he had accumulated fluid rapidly and had vomited a quart of bright red blood, soon followed by two large bloody stools. Hematemesis and melena recurred after admission. The heart was enlarged to the anterior axillary line, with a systolic apical thrill, a grade 3 systolic murmur at the apex, and a loud first mitral sound. The second pulmonary sound was louder than the second aortic and no diastolic murmur was heard. Signs of ascites were present.

The white blood count was 13,000 with 84 per cent neutrophils; clotting time was six and one-half minutes, bleeding time three and one-half minutes; prothrombin time was 50 per cent of normal. The blood urea nitrogen rose to 34 mg. but finally returned to 16 mg. Electrolytes and all other laboratory tests were normal. The electrocardiogram showed atrial fibrillation and digitalis-type myocardial changes. Splenoportogram outlined the splenic hilum with the flow of contrast media through the perisplenic veins to the direction of the para-esophageal plexus. The splenic vein was not visualized, thus suggesting obstruction of the splenic vein close to the splenic hilum.

Soon after admission a Sengstaken tube was inserted and the balloon inflated for 36 hours, but bleeding recurred. On three other occasions he bled severely enough to go into shock upon any attempt to remove the indwelling tube. Eight days after admission he presented a picture resembling hepatic coma and was given Glutavene.® He developed massive edema as well as marked ascites, and 12 days after admission he bled again and went into shock but responded quickly to treatment. Bleeding recurred again, however, and he developed chest rales and died on the fourteenth hospital day. During this stay in the hospital he had been intermittently febrile and his temperature before death was 101°F.

Clinical Discussion

Dr. N. O. Rothermich: The problem we have before us is that of a 56 year old man who presumably was in good health up to six months prior to his first admission to the hospital and died 30 months later. During this time he developed some malignant type of disease which was progressive in nature, tenacious, never let up, and brought about his death within a period of two and one-half years in spite of all types of therapy. His first symptoms almost certainly make this a case of cardiac disease. I think we can say without any hesitation that this man had heart disease and probably primarily heart disease, and maybe exclusively heart disease, since exertional dyspnea, orthopnea, and especially paroxysmal nocturnal dyspnea are symptoms which are predominantly those of heart disease. The paroxysmal nocturnal dyspnea is a peculiar phenomenon that occurs almost exclusively in left-sided heart disease.

Going through his numerous physical examinations I think you readily recognize that he had all the basic findings and symptoms essential for the diagnosis of heart disease. He had cardiac enlargement, he had arrhythmia and he had significant heart murmurs. Why do I say "significant"? He had not only harsh, rumbling, grade 3 systolic murmurs which are *probably* organic in origin, but he also had diastolic murmurs which are *certainly* organic in origin.

A diastolic murmur, you remember, is caused by a flow of blood into the ventricle. If it is blood returning to the ventricle through an insufficient semilunar valve, it will be a pandiastolic murmur usually beginning in the base and perhaps radiating out to the apex. If it is due to blood moving from the left atrium into the left ventricle but held up by resistance, then the murmur is usually diastolic near the apex and most often late diastolic or presystolic in timing. His physical examination describes several different types of diastolic murmurs. At first the murmur was heard throughout entire diastole, but later on the murmur was heard at different times during the diastole.

General Anasarca

The fifth finding that would suggest heart disease is the general anasarca. He had massive edema of his extremities and even more massive fluid accumulation in his abdomen—an ascites that was almost intractable. You will notice that within the six months prior to his first hospitalization he had seven abdominal paracenteses.

When we read in the history that he had had a heavy alcohol intake over many years we might wonder as to the status of his liver, and with this massive ascites there is a strong temptation to feel that he had liver disease. As you read some of the laboratory data on the first hospitalization you might be more inclined to think that he had primary liver disease, particularly with the very low albumin and the reversed albumin/globulin ratio. But this man had seven abdominal paracenteses in a short period of time before he came in and that alone can deplete the albumin stores of the body. I think this contention is borne out by the fact that later his albumin rose to fairly respectable and normal levels.

His liver function studies on the first admission were just slightly on the borderline of abnormal, and the subsequent studies of his liver all were remarkably normal. It is significant too that during the fourth hospitalization he had a biopsy of his liver, which was said to be entirely normal. Furthermore, even though he had massive liver enlargement on his first admission, on subsequent admissions there were times when his liver was relatively normal in size or had receded to where it was no longer palpable. It is true that a man who develops cirrhosis may have a huge liver at the outset, which will gradually shrink to very small size, but this man's liver would get large, shrink and then get large again, apparently varying with the degree of fluid accumulation in his entire body, or with the degree of cardiac failure.

In addition to his heart murmurs, his first mitral sound was loud and snapping—a finding that we like to link with mitral stenosis. When we tried to analyze the valvular disease of this patient we were tempted from the nature of the murmur to think that he had an aortic regurgitation, but then I looked back at the blood pressure and found 108 over 64. It is very,very unusual to see an aortic insufficiency without an elevation of the systolic blood pressure and of course a very low diastolic pressure. And in all subsequent admissions the blood pressure was also comparatively normal. But a second factor that would lead you away from a diagnosis of aortic valvular disease is the failure of the electrocardiogram to show a left ventricular preponderance as evidence of left ventricular hypertrophy, which was also confirmed by the x-ray studies. Without these three symptoms present I would be very much disinclined to a diagnosis of aortic insufficiency.

Mitral Valvular Disease

Because of his left-sided heart disease, because of the type of heart murmurs, and excluding aortic valvular disease, we must assume that the man had severe mitral valvular disease. We can assume that he had rheumatic involvement of the mitral valve, but we must at the same time assume that this was relatively insignificant in a clinical sense since he got along for so many years without any complaints. Something else must have happened to bring on this extreme, intractable failure.

In the history of the first admission it states that the man lost 25 to 30 pounds in that first six month period and this happened during a period when he accumulated fluid. Instead, he should have *gained* a lot of weight. He had a lot of weakness and on admission he was extremely malnourished. Then there is briefly mentioned the story of his S. aureus spinal meningitis four months before he came into University Hospital. Now staphylococcus meningitis is a disease of major significance, and I think we must assume that he had some acute febrile infectious disease in which *Staphylococcus aureus* must have been demonstrated in the spinal fluid. If this is true, then we can be certain that he also had staphylococcus septicemia, and I think it is only fair to assume that his staphylococcus septicemia was the disease that brought about his great debility, his loss of weight, malnutrition and weakness.

But what can a staphylococcic infection in the spinal canal or even in the blood stream do to the heart to set off this mechanism of extreme failure? It is well known clinically that the production of insufficiency of a valve very rapidly will lead to the most intractable type of failure. In the early days of mitral commissurotomy, surgeons learned that the production of a significant degree of mitral insufficiency was a surgical complication that proved catastrophic. The patient would go into massive cardiac failure and die within 24 to 48 hours. Also you are taught, and we know from experience, that a ruptured aortic cusp followed by acute valvular insufficiency will lead to very rapidly progressing cardiac failure and death within a short period of time.

Bacteremia?

We might assume that this man had staphylococcus blood stream infection, that the organism infected a previously damaged mitral valve, and that in the course of this disease labeled as meningitis he had some accute staphylococcus endocarditis which caused ulceration of his valve and thus accentuated rather rapidly his insufficiency. We used to see such a lesion very seldom prior to the days of antibiotics. Acute endocarditis was not a rare disease by any means, but the patients died so fast from their sepsis that their cardiac disability was overshadowed by their severe sepsis. They would die as a rule within six weeks and thus we did not come across this strange entity that I think we are dealing with today—of ulceration from acute endocarditis in which the basic bacterial disease was cured by our present antibiotic therapy, leaving the man with a severe insufficiency which throws him finally into intractable and lethal cardiac failure.

Let us briefly discuss the other types of left-sided heart disease that a 55 year old man can develop. Naturally the first thing you think about is coronary heart disease, but there is nothing in this history that would suggest that this man actually had a coronary thrombosis or myocardial infarction. Could he have active rheumatic heart disease? Yes, it is entirely possible for a person to develop rheumatic fever earlier in life, have little or no symptoms and get along quite well until late in adult life. However, it would be very unusual and highly unlikely for a man to have rheumatic valvular heart disease for a long time and then go into seemingly intractable failure which is unresponsive to good management and to go steadily downhill and die within a matter of two and one-half years.

Could he have had hypertensive heart disease, which is so common at this age? Centainly there is nothing in his history to suggest that. Could he have had one of the more exotic types of heart disease? He could have had Pick's disease, or adhesive pericarditis, but that would not explain anything about what was going on inside his heart. He may have had some sort of band formation across his inferior vena cava at its entrance to the heart. This would easily explain all of his accumulation of fluids but again would have nothing to do with his heart or with his lungs, and I think then we can discard both possibilities.

Another unusual disease that affects the heart is primary amyloidosis. It occurs in individuals of this age level and always involves the myocardium like all other skeletal muscles. But primary amyloidosis almost always has conduction disturbances such as intraventricular and atrioventricular heart block and usually leads to complete heart block. We might also mention hemochromatosis and a lot of other diseases, but I just don't believe there is a remote possibility of them in this case.

Ascites

There are other symptoms in his clinical course that make one wonder if some other factors did not complicate the picture. In the first place the outstanding feature of fluid accumulation all through his illness is that it was in the form of ascites. Athough there were times when he had massive dependent edema, still the thing that pervades the whole story is the accumulation of ascites.

Then we note that a hepatic vein wedge pressure was taken and that this pressure was normal. A wedge pressure of the hepatic circulation gives some index of the pressure in the portal circulation, and if that is normal it is hard to explain his ascites, it is hard to explain his heart failure, it is hard to explain everything unless he had a portal vein thrombosis, in which case then there would be a normal wedge pressure in a hepatic vein.

Portal vein thrombosis is a complication of considerable magnitude. I have only seen a few cases in the past 20 years. Those I have seen developed massive ascites and edema below the diaphragm and did not survive more than a few months. However, I suppose that with energetic management, diuresis, etc., and with greater adequacy of collateral circulation, one could have a portal thrombosis and survive for a reasonably long period of time. He did have bleeding varicosities of the esophagus and did show at one stage a thrombophlebitis in one leg, which would support the concept of an increased clotting mechanism. Finally the fact that he was in congestive failure would make him a likely candidate for vein thrombosis anyway.

So, Dr. von Haam, I have to offer you a man who went into severe, intractable cardiac failure at the age of 56, who had evident heart disease with quite obvious organic valvular disease, who responded poorly to cardiac management although on a couple of occasions his heart failure did presumably subside entirely. Eventually he went downhill and died with this problem of massive anasarca. I think that he probably had rheumatic heart disease with involvement of the mitral valve, that he may have had an acute endocarditis which caused valvular ulcerations and accentuated his insufficiency, and that he may well have developed a portal thrombosis to complicate the picture. This could well explain his massive ascites and the esophageal varices.

General Clinical Discussion

Dr. William Molnar (radiologist): On the first admission this patient had only left atrial enlargement. Later there occurred some right and left ventricular enlargement, so we could easily state from a radiological point of view that he had regurgitation but no mitral stenosis or aortic regurgitation. The films taken at splenoportography did not demonstrate the splenic vein or the portal vein. But we have evidence that there were increased venous channels around the spleen which had direct communication and anastomotic channels to the para-esophageal plexus and to the azygos system.

I wonder if the patient had a splenic infarct or a portal vein thrombosis or some chronic inflammatory process in the form of pancreatitis which may have caused this obstruction or pressure on the splenic vein. I do not believe that his ascites was due to cardiac failure, but I believe that there was some other underlying disease which caused the ascites.

Clinical Diagnosis

1. Rheumatic heart disease, probably inactive.
2. Acute bacterial endocarditis with severe insufficiency of the mitral valve.
3. Portal vein thrombosis.
4. Bleeding esophageal varices.

Pathological Diagnosis

1. Acute bacterial endocarditis with perforation of mitral valve.
2. Septic myocarditis.
3. Fibrosis of pancreas with obstruction of splenic vein.
4. Phlebosclerosis and calcification of splenic vein.
5. Esophageal varices with hemorrhage.
6. Septicemia.

Pathological Discussion

DR. EMMERICH VON HAAM: I may state that the official clinical diagnosis at the time of the patient's death was liver cirrhosis with bleeding esophageal varices. The patient was poorly nourished and his abdomen contained 3000 cc. of ascitic fluid, but he had no pedal edema when he died. The pericardial sac was partially obliterated by diffuse fine adhesions. His heart was enlarged and weighed 475 grams. The mitral leaflets were slightly thickened and nodular and the right leaflet contained a sharply punched-out hole at its base measuring 15 by 8 mm. The base of the left valve leaflet showed a saclike dilatation measuring 12 by 9 mm. which was filled with friable vegetations. Otherwise the valves of the heart appeared normal.

The lungs were heavy and edematous and the trachea was filled with aspirated blood which probably came from his terminal hemorrhage and was the immediate cause of death. The spleen was enlarged and weighed 500 grams. The splenic vessels were encased in dense fibrous tissue surrounding the pancreas. The liver was slightly decreased in size, soft and congested. The gallbladder was filled with small black stones. The pancreas was small and fibrosed with dilated ducts and complete disappearance of the normal acinolobular pattern. The esophagus showed a 13 cm. linear erosion and the stomach contained 20 cc. of coffee-ground material.

The remaining portion of the gastrointestinal tract was not remarkable. The kidneys were large and contained numerous small yellow and red infarcts. Examination of the remaining parts of the body including the brain was grossly not remarkable.

Microscopic Examination

Sections through the heart valve showed endocardial thickening with abundant vegetations containing numerous bacterial colonies. No vegetations were present on the margin of the perforation. The myocardium was riddled with abscesses containing colonies of cocci. Similar bacterial abscesses were also found in the spleen, liver, kidneys, brain and spinal cord. The esophagus contained varicose veins with ulceration of the mucous membrane.

The liver showed congestion with very mild nutritional cirrhosis. The pancreas showed changes of chronic pancreatitis with severe interstitial and peripancreatic fibrosis. The wall of the splenic vein was thickened with extensive calcification and marked compression of the lumen. The spleen showed the typical changes of congestive splenomegaly with adenofibrosis.

In summary then I may state that this patient suffered from bacterial endocarditis which had produced a perforation of the mitral valve causing acute mitral insufficiency. Modified in its lethal course by the use of antibiotics, it nevertheless continued and finally led to septicemia with bacterial embolization. The ascites and the esophageal varices were due to a severe nonthrombosing pylephlebitis of the splenic vein due to severe chronic pancreatitis. I wish to congratulate Dr. Rothermich for his fine clinical analysis by which he recognized the fatal heart disease of this patient, and Dr. Molnar for his interpretation of the splenoportogram which suggested the true cause of his portal hypertension.

Treatment of Myocardial Infarction With Anticoagulants

The study embraces a six-year period (1951 through 1956) and deals with the results obtained in 136 patients with acute myocardial infarction who were treated with anticoagulants. Not included in the study are those patients who died within 24 hours of admission. . . .

The patients were arbitrarily (and retrospectively) divided into "poor risk" and "good risk" groups, roughly according to Russek's criteria, depending upon the findings on the first day of illness. If any of the following were present, the risk was considered poor: (1) intractable pain (2) persistent shock (3) heart failure (4) cardiomegaly (5) serious arrhythmia or block (6) presence of diabetic acidosis or other serious concomitant illness and (7) history of previous myocardial infarction. All other patients were considered good risks, regardless of age. According to these criteria, 76 of the 136 patients were classified as "poor risk" and 60 were "good." All were given full anticoagulant therapy.

Of the 76 poor risks, 20 (27 per cent) died of their illness. Of the 60 patients considered good risks, one case proved fatal (1.7 per cent). The overall mortality rate was 15.4 per cent.—John F. Stegeman, M.D., et al., Athens, Ga.: *J.M.A. Georgia,* 47:72, February, 1958.

The Achievements of Arist

...in Skin Diseases: In a study of 26 patients with severe dermatoses, ARISTOCORT was proved to have potent anti-inflammatory and antipruritic properties, even at a dosage only ⅔ that of prednisone[1]... Striking affinity for skin and tremendous potency in controlling skin disease, including 50 cases of psoriasis, of which over 60% were reported as *markedly improved*[2]...absence of serious side effects specifically noted.[1,2,3]

...in Rheumatoid Arthritis: Impressive therapeutic effect in most cases of a group of 89 patients[4]... 6 mg. of ARISTOCORT corresponded in effect to 10 mg. of prednisone daily (in addition, gastric ulcer which developed during prednisone therapy in 2 cases disappeared during ARISTOCORT therapy).[5]

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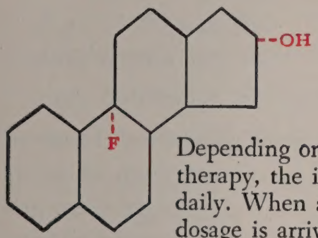
Triamcinolone **LEDERLE**

...in Respiratory Allergies: "Good to excellent" results in 29 of 30 patients with chronic intractable bronchial asthma at an average daily dosage of only 7 mg.[6]... Average dosage of 6 mg. daily to control asthma and 2 to 6 mg. to control allergic rhinitis in a group of 42 patients, with an actual reduction of blood pressure in 12 of these.[7]

...in Other Conditions: Two failures, 4 partial remissions and 8 cases with complete disappearance of abnormal chemical findings lead to characterization of ARISTOCORT as possibly the most desirable steroid to date in treatment of the nephrotic syndrome.[8,9]... Prompt decrease in the cyanosis and dyspnea of pulmonary emphysema and fibrosis, with marked improvement in patients refractory to prednisone.[10,11,12]... Favorable response reported for 25 of 28 cases of disseminated lupus erythematosus.[13]



Depending on the acuteness and severity of the disease under therapy, the initial dosage of ARISTOCORT is usually from 8 to 20 mg. daily. When acute manifestations have subsided, maintenance dosage is arrived at gradually, usually by reducing the total daily dosage 2 mg. every 3 days until the smallest dosage has been reached which will suppress symptoms.

Comparative studies of patients changed to ARISTOCORT from prednisone indicate a dosage of ARISTOCORT lower by about ⅓ in rheumatoid arthritis, by ⅓ in allergic rhinitis and bronchial asthma, and by ⅓ to ½ in inflammatory and allergic skin diseases. With ARISTOCORT, no precautions are necessary in regard to dietary restriction of sodium or supplementation with potassium.

ARISTOCORT is available in 2 mg. scored tablets (pink), bottles of 30; and 4 mg. scored tablets (white), bottles of 30 and 100.

Lederle LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK

Group Life Insurance Plan for Members of th

Coverages of $10,000, With Option To Buy $10,000 More, Will Be Underwritten by The Union Central Life Insurance Co., Cincinnati

AN excellent Group Life Insurance Plan, available to all members of the Ohio State Medical Association who have not attained the age of 75 years, was adopted by The Council on June 8.

All members should watch for the direct mail information on the plan which will be sent in the near future, accompanied by an application form.

The coverage is being underwritten by The Union Central Life Insurance Company of Cincinnati.

The insurance contracts will be sold and the plan administered by Floyd L. Turner, C. L. U., and Arthur E. Shepard, C. L. U., general insurance agents of Columbus, doing business as Turner & Shepard, Inc.

Possible To Get $20,000 Coverage

The amount of insurance offered any one member is $10,000 **without** evidence of insurability and an option to him to buy at the same rate an additional $10,000 **with** evidence of insurability.

At age 65, each $10,000 purchased will reduce to $6,750 for ages 65 through 69; to $4,500 for ages 70 through 74.

The premium payable is on a step-rate basis according to age brackets with the exception of the 65 to 75 age bracket when the premium remains constant but the insurance reduces as stated in the foregoing paragraph.

Available To Employees of Physicians

To comply with the State law, life insurance coverage of $2,000 under the plan is available without evidence of insurability **to any employee of OSMA members who may desire to participate.** The premium on coverage for employees is on a step-rate basis according to age brackets. The coverage for employees includes all features of the coverage offered to their physician-employers.

Double Indemnity; Waiver of Premium

The group insurance coverage includes double indemnity for accidental death and dismemberment.

Waiver of premium in event of permanent and total disability prior to age 60 is included.

There are no exclusions for death while in the military service or as a result of aviation. However, double indemnity, **does not** apply for accidental death or dismemberment in case of death or injury resulting from military service or aviation **except commercial airlines.** Also, the waiver of premium provision **does not** apply in disablement resulting from military service or aviation, **except commercial airlines.**

Paid up Permanent Insurance Through Dividends

The group insurance contract includes full settlement options, i. e., like those in individual insurance contracts.

Dividends will be used to purchase paid-up permanent insurance for each member participating in the plan.

The paid-up insurance purchased from the dividends may be cashed in by the participating member.

All OSMA members, whether or not engaged in active practice, are eligible to participate in the plan.

A participating member will be permitted to convert his group insurance **without evidence of insurability** to a permanent form of life insurance after five years participation in the plan; or at termination

OSMA Voted by Council at June 8 Meeting

Employees of Members Also May Purchase Policy; Many Excellent Features Included, Such as Waiver of Premium and Double Indemnity

of membership; or at age 75; or when the amount of insurance reduces. Premium charged on converted insurance will be the premium charged at the age at time of conversion.

Need 1,000 Enrollees To Make Plan Effective

The plan will become effective as soon as the first 1,000 participating members or employees have been enrolled.

After the initial state-wide enrollment period (i. e., perhaps 60 days), members and their employees may enroll at semi-annual renewal dates. **However, those not enrolling during the initial state-wide enrollment period will have to show evidence of insurability in order to secure coverage at a later date.**

New members of the OSMA and their employees may enroll without evidence of insurability on the semi-annual renewal date following admission to membership in the Association.

Tabulation on Premiums Charged

The following tabulation shows the premiums charged for the Ohio State Medical Association Group Life Plan, including an administration fee, and compares these with the higher premiums charged for **individual** term insurance contracts as issued by the same company—the Union Central.

OSMA Group Life Insurance Plan (Semi-Annual Premium)		Individual Term Insurance (1) (Semi-Annual Premium)	
Under Age 30	$ 23.40	Age 29(2)	$ 50.80
Ages 30 through 39	$ 31.15	Age 30(2)	$ 52.40
Ages 40 through 49	$ 53.65	Age 40(2)	$ 77.20
Ages 50 through 54	$ 86.95	Age 50(2)	$121.80
Ages 55 through 59	$125.30	Age 55(2)	$177.30
Ages 60 through 64	$183.45	Age 60(2)	$206.90(3)
Ages 65 through 69 ($6,750 Ins)	$183.45	Not Available	
Ages 70 through 74 ($4,500 Ins)	$183.45	Not Available	

(1) Subject to evidence of insurability.

(2) Age shown is youngest age in the group bracket. For other ages in bracket, the individual premiums would be larger.

(3) Accidental death not included.

The semi-annual cost for the $2,000 insurance offered employees under the Ohio State Medical Group Life Plan is about 20% of the amount shown above in the various age brackets in the left-hand column.

Special Committee Worked on Plan

The plan being offered by the Association was formulated after six-months work on the part of a special committee composed of Dr. H. M. Clodfelter, Chairman, Dr. C. C. Sherburne, and Dr. Roger E. Heering. Dr. Clodfelter and Dr. Sherburne are former presidents of the Association.

It was during Dr. Clodfelter's term as president when the House of Delegates of the Association approved a resolution authorizing the Association to present a Group Life Plan to the membership.

(Continued on Page 928)

At that time, this could not be done under the State Insurance laws. This was corrected at the last session of the Legislature when an amendment authorizing the underwriting of professional groups for life insurance was adopted.

The special committee interviewed representatives of agencies applying for the job of administering the plan. It considered suggestions from various insurance companies.

After careful analysis, the committee found that the proposal submitted by The Union Central Life Insurance Company more nearly complied with certain specifications laid down by the committee than any of the other proposals considered by the committee.

Union Central Outstanding Company

The Union Central Life Insurance Company is one of Ohio's leading insurance companies and ranks among the leaders in the insurance field nationally. It was organized in Cincinnati in 1867.

In its official financial statement for the year ending December 31, 1957, Union Central showed the following:

Assets	In excess of $ 800,000,000
Paid to policyholders and beneficiaries to date	In excess of $1,500,000,000
Amount of insurance in force	In excess of $2,400,000,000
Total group insurance in force	$ 715,000,000

President of Union Central is John A. Lloyd, former superintendent of the Ohio Department of Insurance and former member of the Ohio Senate.

Turner - Shepard Agency Experienced

The Turner-Shepard Agency was organized in 1929. It has specialized in association group insurance since 1943. At present it is administering disability group insurance for members of 28 County Medical Societies in Ohio, including the Columbus Academy of Medicine and the Montgomery County Medical Society. In addition, Turner-Shepard Agency administers five regional association plans and five state-wide association group insurance plans, including that of the Ohio Bankers' Association. It has a staff trained in group insurance administration; has four full-time representatives working throughout the state; has working arrangements with insurance brokers in all major Ohio cities. The officials and experienced personnel of the Union Central Group Life Department will assist Turner and Shepard in soliciting members of the OSMA and in handling other details.

Ohio Has 369 Foundations with Assets of $250-Million

Philanthropic foundations in Ohio have assets of $250,000,000 and have made grants of more than $21,000,000 in single years, according to findings of a survey announced by American Foundations Information Service.

The survey revealed 369 foundations in the State, as compared to 162 found in a similar study in 1955. Since the previous survey, total assets have increased by $125,000,000; grants in single years, by $13,000,000.

Among sponsors and supporters of recently discovered foundations in the State are 120 business firms and 249 individuals and families, according to the survey. Predominant fields of interest are education, health and medicine, and various aspects of social welfare.

Ohio Chest Physicians Elect Officers

The following are the newly elected officers of the Ohio Chapter, American College of Chest Physicians: Dr. Harvey Mendelsohn, Cleveland, President; Dr. George Kress, Columbus, vice-president, and Dr. F. G. Kravec, 243 Lincoln Avenue, Youngstown, secretary-treasurer.

Fort Steuben Academy

The Fort Steuben Academy of Medicine and the Committee on Trauma of the American College of Surgeons sponsored the Annual Trauma Symposium in Steubenville recently. Dr. R. Arnold Griswold, professor of surgery, University of Louisville, spoke on the subject, "Prevention of Injury in Automobile Accidents." Discussion was opened by Sgt. R. H. Shaneyfelt, of the Ohio Highway Patrol.

Proceedings of The Council . . .

Preliminary Plans Made for 1959 Annual Meeting in Columbus Next April; A Statement of Policy on Unauthorized Practice Is Approved

A REGULAR meeting of The Council of the Ohio State Medical Association was held in the Columbus office on Saturday and Sunday, June 7 and 8, 1958. In addition to all members of The Council, the following were in attendance: Dr. Charles L. Hudson, Cleveland, chairman of the Committee on Medical Services; Dr. C. C. Sherburne and Dr. R. E. Heering, Columbus, members of the special Committee on Group Life Insurance; Mr. Wayne E. Stichter, Toledo, legal counsel; and Messrs. Nelson, Saville, Page, Edgar and Moore.

By official action, the minutes of the meetings of The Council held on March 1 and April 17 **were approved.**

Membership Data

The following membership data was presented by the Executive Secretary: OSMA membership as of June 6, 1958, 8,896; compared to a total membership of 9,070 members as of December 31, 1957.

Members of the OSMA affiliated with the AMA as of June 6, 1958, 7,828; compared to a total of 8,030 who were 1957 AMA members.

1959 Annual Meeting

After reviewing the 1958 Annual Meeting in Cincinnati which, in the opinion of the members of The Council, was a very successful meeting, The Council discussed plans for the 1959 Annual Meeting in Columbus.

It was decided that the meeting should be held on Tuesday, Wednesday, Thursday and Friday, April 21, 22, 23 and 24. All sessions will be held in the Veterans Memorial Building.

Also, it was decided that the program for the first day would be devoted primarily to cancer and heart disease, and that the Ohio Division of the American Cancer Society and the Ohio State Heart Association should be invited to hold their meetings on that day and present the program material.

Inasmuch as the Ohio State University College of Medicine will celebrate its 150th anniversary in 1959, The Council extended an invitation to the medical school to have its sesquicentennial celebration the week of the 1959 OSMA Annual Meeting. Specifically, The Council voted to invite the Ohio State University College of Medicine to present the Friday program, utilizing, if it desired, distinguished OSU medical alumni. It was understood that the medical school would wish to have a banquet on Friday evening, April 24, and medical alumni class reunions on the campus on Saturday, April 25.

The Committee on Scientific Work was asked to take all of these decisions into consideration and to cooperate with all concerned in working these features into the 1959 Annual Meeting program.

By official action, The Council selected the meeting places and dates for 1961 and 1962 as follows: 1961, Cincinnati, the week of April 16; 1962, Columbus, the week of May 13. Previously The Council had selected Cleveland for the 1960 Annual Meeting the week of May 15.

Constitutions and By-Laws

Action was taken, as follows, by The Council on new constitutions and by-laws of the county medical societies indicated or amendments to the constitutions and by-laws of such societies:

Belmont County—Action was delayed pending a conference between representatives of the medical society and OSMA legal counsel on certain amendments.

Coshocton County—Approved in final form following the adoption of changes suggested by Council at its meeting on March 1.

Jefferson County—Approved as adopted by the society and presented to The Council.

Scioto County—Approved in final form, providing certain typographical errors are corrected and clarifying phrases suggested by The Council are agreed to and inserted.

Van Wert County—Approved in final form following the adoption of changes suggested by Council at its meeting on March 1.

Wayne County—Approved in final form following the adoption of changes suggested by Council at its meeting on March 1.

Unauthorized Practice of Medicine

By unanimous vote, The Council approved a statement of policy regarding the unauthorized practice of medicine by partnerships, associations, institutions, corporations and unlicensed persons, and the ethical status of physicians aiding or abetting, or participating in, such un-

authorized practice. (See page 935 this issue of *The Journal.)* This statement was drafted by the Judicial and Professional Relations Committee and the Committee on Hospital Relations. The committees spent approximately one year studying this question, pursuant to a resolution adopted by the House of Delegates on May 16, 1957. The committees met jointly and held many conferences with specialists, groups and organizations vitally interested in this question, including the Ohio Hospital Association and others. In approving the statement presented by the committees, The Council commended the committees for their excellent work.

By official action, The Council instructed the Executive Secretary to prepare a pamphlet for distribution to all members in which would appear this statement, as well as the statement of policy adopted at the December meeting of The Council on Third Party Medical Care Plans.

Conference Suggested

The Council then considered a communication from Dr. Frank C. Sutton, chairman of the Professional Relations Committee of the Ohio Hospital Association. This letter recommended that the Ohio State Medical Association and the Ohio Hospital Association consider the possibility of amending the Medical Practice Act of Ohio so as to clarify the status of hospitals and certain specialists working in hospitals so far as the corporate practice of medicine is concerned.

By official action, The Council instructed the Judicial and Professional Relations Committee and the Committee on Hospital Relations to sit jointly with representatives of the Ohio Hospital Association for the purpose of considering the question raised by Dr. Sutton and any recommendations which might be forthcoming from the Ohio Hospital Association on this subject.

Ohio Society of Medical Assistants

The Council received a report regarding the Ohio Society of Medical Assistants from a special committee of The Council composed of Dr. George W. Petznick, Cleveland, chairman, Dr. Paul F. Orr, Perrysburg, and Dr. Carl A. Gustafson, Youngstown. The committee advised The Council that the Ohio Society of Medical Assistants, at a recent meeting in Hamilton, Ohio, had approved the Constitution and By-Laws, drafted by the special committee for consideration of that organization, with only two very minor changes.

Following a general discussion, by official action, **The Council voted its approval of the Ohio Society of Medical Assistants** and instructed the Executive Secretary to notify the officers of that Association accordingly.

Group Life Insurance Plan

The Council then considered reports from the special committee designated last year to present a group life insurance proposal, to be considered by The Council, for presentation to OSMA members. The special committee was composed of Dr. H. M. Clodfelter, chairman, Dr. C. C. Sherburne and Dr. R. E. Heering.

The committee presented a proposal which had been drafted by The Union Central Life Insurance Company and recommended its adoption. Also, the committee recommended that the insurance agency of Turner and Shepard, Columbus, be designated as official administrators of the plan.

By official action, The Council approved both recommendations of the special committee, (See page 926 this issue of *The Journal,*) and instructed the special committee to work out a mutually acceptable working agreement with Turner & Shepard for putting the program into effect at an early date.

Belmont County Case

A lengthy communication from Dr. Murray B. Hunter, Bellaire Clinic, Bellaire, Ohio, was considered. The communication alleged that the Belmont County Medical Society acted contrary to its constitution and by-laws in rejecting the applications for admission to membership of three Belmont County physicians.

Following a long discussion, **The Council instructed the Executive Secretary to advise Dr. Hunter** that it is the considered opinion of The Council that it does not have any jurisdiction to overrule or set aside the action of a component medical society, taken pursuant to its constitution and by-laws, in rejecting an applicant for membership; and that The Council found no evidence in the material submitted by Dr. Hunter to show that the Belmont County Medical Society acted illegally or otherwise under its own constitution and by-laws than in the proper exercise of its rights under its own constitution and by-laws.

Report of Committee on Medical Services

Dr. Charles L. Hudson, Cleveland, chairman of the Committee on Medical Services, was asked to report on a meeting of his committee held on Saturday afternoon, June 7. He reported as follows:

Medicare Program

A letter from Major General Robinson, Executive Director of the Medicare Program, dated March 11, was discussed by the committee. The letter acknowledged a communication of March 7 sent to General Robinson advising him of the action of The Council, March 1, 1958, declining to sign a Medicare contract for the year 1958. It was ordered filed.

There was a general discussion of the Medicare situation nationally, including the Texas action in withdrawing from the Medicare Program; resolutions from various states to be introduced at the San Francisco AMA meeting; Congressional action to date limiting the amount of money for the Medicare Program, which may mean that more Medicare patients will have to be taken care of in military installations rather than by physicians in private practice. The committee felt that no action by the OSMA on these matters was necessary at this time.

VA Medical Program in Ohio

Reference was made to the fact that the new Veterans Administration medical setup in Ohio will take effect on July 1 and that the fee schedule suggested by the OSMA had been accepted by the VA with only three minor changes. Complete details on this will be published in the August *Journal.*

The committee was advised of a letter dated May 28 from the AMA Council on Medical Service to the AMA Committee on Federal Medical Services. The letter stated that perhaps certain VA tuberculosis hospitals would be declared "surplus" and that it might be that some of these institutions could be turned over to the state or local communities to be used as public hospitals—perhaps chronic disease hospitals. The committee was advised that this decision, if made, might pertain to the VA hospital at Brecksville, which is the only VA tuberculosis facility in Ohio. The committee instructed the Executive Secretary to refer this to the Cleveland Academy of Medicine for study and advice.

Fees Paid by Federal and State Agencies

The following letter from Dr. Arnoldus Goudsmit, Youngstown, President of the Ohio Society of Internal Medicine, dated February 7, was discussed:

"At the annual meeting of The Ohio Society of Internal Medicine held in Cleveland on January 22, 1958, we unanimously adopted the following resolution, and I was instructed to forward it to you for the attention of the Council of the Ohio State Medical Association. The resolution reads as follows:

'The Ohio Society of Internal Medicine is firmly convinced that whenever any agency of the Federal or State Government, or any other agency, assumes responsibility for the medical care of any group in our population, that such a group shall not be considered as medically indigent, and that fair and standard fees based on those usually assessed for professional services of similar quality for private and non-indigent patients be recognized as the acceptable basis for negotiations.'

"Kindly allow me a few words of explanation. In the past, agreements between state medical societies and agencies of government have been geared to the situation where semi-charity existed, or was supposed to be involved as one of the considerations. We believe that in the past circumstances and emergencies may have existed which made the acceptance of that type of fee structuring understandable.

"We believe that the time has come, and is here now, when the medical profession should stand up and point out to the governmental agencies concerned that they are not in the habit of asking any other group of workers or professional men to accept woefully sub-standard compensation for competent services rendered. In times past, due to the relatively small volume of that type of work carried out by any one practitioner, a sub-standard arrangement may not have provided a significant hardship on any one man. However, with the extension of government and private prepaid type of medical plans obviously increasing, this situation may not continue to exist much longer. We believe there is a special reason why the qualified internists of this State, of which this Society represents the sole means of verbalizing their problems, feel particularly strongly on this subject inasmuch as, in the past, the services provided by the internists have received, with few exceptions, most inadequate consideration.

"If so desired, I would be happy to further elucidate on the subject of this resolution and related material at your request, and at your convenience."

The committee instructed the Executive Secretary to advise Dr. Goudsmit that the principles outlined in the letter were in keeping with the general policy of the OSMA and undoubtedly would be taken into consideration by The Council in all future contacts with governmental agencies. The committee also stated that the letter should point out that the Association would welcome the advice and suggestions of the Ohio Society of Internal Medicine on all such matters.

Fees Paid Consultants at Columbus State Hospital

A letter from a Columbus physician was discussed by the committee and with Dr. Robert A. Haines, Director, Department of Mental Hygiene and Correction, who attended the meeting for this purpose, on invitation of the committee. It pointed out the inequity of payments made to consultants serving the Columbus State School.

Dr. Haines pointed out that this problem arose primarily because of (1) a ruling by the State Auditor that physicians, to be on a part-time basis, must devote at least 20 hours per week in actual services in a state institution; and (2) inadequate funds to properly compensate physicians as consultants. Dr. Haines stated that it was not feasible to require so-called part-time physicians to actually put in 20 hours per week. In order to compensate such physicians in some other way an effort was made to place them in the consultant category. In doing so the Columbus State School ran into budget trouble.

There was considerable discussion as to ways and means of trying to remedy the situation as it was felt by all present that the present procedure of reimbursement is entirely inadequate and inequitable.

It was agreed that Dr. Haines would discuss this problem with the superintendents of the various state hospitals and state schools, and appear before this committee at a later date. He was asked particularly to present data at the next conference on the possibility of each institution having a special fund from which physicians, other than staff physicians, could be paid for services rendered; what amounts would be needed at each institution; what methods of compensating the physicians should be used, and whether or not it would be feasible to leave that matter entirely to the discretion of the superintendent of each institution.

Third Party Medical Care Plans

The committee discussed the question of third party medical care plans, especially the situation with respect to the United Mine Workers Welfare and Retirement Fund program. Reference was made to correspondence between the Executive Secretary and the Public Relations Department of the AMA on a proposed article in *Today's Health* written by a professional writer named "Herndon." The Executive Secretary was asked to send copies of this correspondence to members of the committee at his convenience.

The following letter from Dr. Warren F. Draper, Executive Medical Officer of the UMW program, in reply to a letter from the Executive Secretary dated May 14, which was accompanied by Resolution No. 12, adopted at the Cincinnati Annual Meeting, was read and discussed. The resolution asked that the UMW program be put on an indemnity basis.

"In reply to your letter of May 14, 1958, I must say that we are quite familiar with the principles of indemnity payments and know that neither the quality nor cost of services which beneficiaries would receive under a plan like this would be satisfactory to the Fund.

"A meeting of those concerned with Labor Health Services throughout the country will be held in Washington next month to consider the objectives which they have in common and the manner in which they may best be attained.

"The information and understanding resulting from this Conference may serve as a basis for better understanding on the part of all of those concerned as time goes on.

"Thank you for your courteous letter."

The committee felt that no action by the committee was necessary at this time.

The committee advised the Executive Secretary that it felt that no follow-up action would be necessary at this time with respect to Resolution No. 14, adopted at the recent Cincinnati Annual Meeting, as the situation complained of has been remedied.

Pathological Services

The committee felt that a copy of Resolution No. 1, adopted by the House of Delegates at the Cincinnati Annual Meeting, with an appropriate letter should be sent to Medical Mutual of Cleveland, and instructed the Executive Secretary to follow through on this.

Aid for the Aged Program in Ohio

A letter from Dr. F. C. Curtzwiler, Toledo, Secretary of the Ohio State Radiological Society, with respect to fees paid by the Division of Aid for the Aged for radiological procedures, was discussed. The committee felt that the Executive Secretary's letter to Dr. Curtzwiler in reply to his letter was satisfactory. It suggested that this letter be placed in the file of the new committee on problems of the aged, which would handle all matters with respect to the Division of Aid for the Aged medical care program in the future.

Correspondence from Mr. Edward F. Willenborg, Executive Secretary of the Cincinnati Academy of Medicine, with respect to correspondence between a physician and the Division of Aid for the Aged, was discussed.

The committee instructed the Executive Secretary to advise Mr. Willenborg, and for him in turn to advise the physician, that the solution to some of the questions in the correspondence hinges on more adequate appropriations for the program which would enable the Division to remove certain restrictions on the number of visits, etc.

At this point the committee engaged in a gen-

Dates and Places for Annual Meetings In Years 1959, 1960, 1961 and 1962

For the information of all members, and especially members or others who may have the responsibility of setting meeting dates for certain organizations, the following places and dates for future Annual Meetings of the Ohio State Medical Association will be valuable for reference:

1959 meeting . . . Columbus . . . April 21, 22, 23 and 24
1960 meeting . . . Cleveland . . . week of May 15
1961 meeting . . . Cincinnati . . . week of April 16
1962 meeting . . . Columbus . . . week of May 13

eral discussion with respect to the Division of Aid for the Aged medical care program. The committee instructed the Executive Secretary to discuss with Mr. Richard C. Minor, Assistant Director of the Ohio Department of Public Welfare, the possibility of a definite policy statement to the effect that a physician may look to a recipient of aid for the aged or his relatives, or anyone else, for part-payment for medical services in event the physician's customary fee for patients of this economic status is larger than the fee allowed under the Division's uniform fee schedule.

Reference was made to the report of the Governor's Commission on Aging, which among other things is recommending that the ceiling of $65.00 on Aid for the Aged pensions be eliminated and that more money be appropriated for the medical program.

Before adjourning the committee decided that it would be appropriate for the new Committee on Care of the Aged to take over all matters relating to the aged, including the Division of Aid for the Aged medical health care program, which up to this time have been handled by the Committee on Medical Services.

By official action, The Council approved the report presented by Dr. Hudson for the Committee on Medical Services.

Maternal Health

Mr. Page reported for the Committee on Maternal Health. He stated that the committee is planning an outline for a talk on "Guiding Principles for Obstetric Care" with slides and will encourage county medical societies to devote programs to maternal health using members of the committee. Also, it was reported that the committee is planning to produce an exhibit suitable for county and district medical meetings and the state meeting.

Resolutions Assigned to Committees

At the request of the Executive Secretary, The Council assigned to various committees certain resolutions adopted at the recent Cincinnati Annual Meeting, as follows:

Resolution No. 9, regarding aid for the aged, to the new Committee on Care of the Aged.

Resolution No. 11, regarding traffic safety, to the new Committee on Traffic Safety.

Resolution No. 13, regarding poison controls, to the new Committee on Poison Control.

Resolution No. 16, regarding the Hughes-Griswold Act, to the Committee on Public Relations and Economics.

Resolution No. 17, regarding medical care for migrant laborers, to the Committee on Public Relations and Economics.

Resolution No. 19, regarding a welfare and retirement plan for OSMA members, to the Committee on Auditing and Appropriations.

Mental Guidance Center

A communication from the Stark County Medical Society, asking for advice on the difference of opinion between the society and the Stark County Mental Guidance Center, was discussed. The Executive Secretary was requested to secure information from the Director of Mental Hygiene and then to write the Stark County Medical Society on the basis of the information obtained.

Chicago Pharmacal Proposal

Certain promotional material of the Chicago Pharmacal Company was discussed. This material included a proposal offering insurance against fetal mortality for any person using one of the company's drugs on a physician's prescription. It required the filling out of a form by the attending physician. The Council felt that this promotional material was improper; expressed the belief that perhaps the physician would be violating the Principles of Medical Ethics; and might be running the risk of being charged with the unlawful sale of insurance. The Executive Secretary was instructed to express the views of The Council on this in an issue of the *OSMAgram.*

Letter of Thanks

A letter from the president of the Ohio Society of Internal Medicine, Dr. Arnoldus Goudsmit, Youngstown, thanking The Council for securing an upward adjustment of fees paid by the disability section of the Bureau of Vocational Rehabilitation, was read and ordered filed.

Traffic Safety Report

A communication from Dr. Drew L. Davies, reporting on the meeting of the President's Committee on Traffic Safety, held in Chicago on April 1 and 2, was ordered transmitted to the new Committee on Traffic Safety for its consideration and guidance.

By official action, The Council instructed the Executive Secretary to send a congratulatory letter on behalf of The Council to Dr. Arthur S. Flemming, President of Ohio Wesleyan University, concerning his appointment as secretary of the U. S. Department of Health, Education and Welfare.

Mr. Page was instructed to represent the Association on the advisory committee to the Ohio Association for Adult Education as requested by that organization.

Forand Bill

The President was authorized to send a letter to Ohio Congressmen at the time the Forand bill is up for a hearing, enumerating the steps being taken in Ohio to try to solve the problems of the aged and pointing out objections to the bill.

Pre-Election Conferences

Mr. Saville asked the advice of The Council as to the times and places for the usual pre-election conferences this coming Fall. Members of The Council approved the schedule as reported by him.

During the reports of Councilors, Dr. Elliott stated that representatives of the counties in the Third and Fourth Councilor Districts had decided that no meeting of the Northwestern Ohio Medical Society should be held this year. It was decided, he said, to hold a meeting in Findlay in the Fall of 1959, at which time an effort will be made to decide whether or not future meetings shall be held or the society dissolved.

Following reports by other Councilors on their districts, The Council adjourned to meet in Granville on September 12, 13 and 14, or sooner at the call of the President.

Attest: CHARLES S. NELSON,
Executive Secretary.

Study of Hospital - Medical Economics In Michigan

A comprehensive two-year study of Michigan's hospital and medical economics, under the direction of the University of Michigan, is under way.

The study was requested by the Governor's Commission on Prepaid and Medical Care Programs and will be financed by a $325,760 grant from the Kellogg Foundation.

The study will include the following:

1. A survey of hospitals, allied institutions, and agents in terms of services offered, general program, effectiveness of organization, and cost elements will be conducted to determine what health facilities and programs exist in Michigan which might logically fall within the realm of health insurance and prepayment, either on a service or indemnity basis.

2. Hospital and medical prepayment and insurance plans will be examined with specific reference to internal operation, costs, benefits, and contract limitations.

3. The relationships between contract benefits, availability of services, and use of benefits and services by patients will be studied.

4. The effectiveness of various proposals to control hospital and medical costs will be examined.

5. Hospital efficiency in terms of use of available facilities, timing of services, accounting, automation and substitute skills, medical staff organization, and regional planning will be investigated.

6. The problem of additional charges by physicians in respect to service contracts and the relationship, if any, between physician expenses to the patient and the extent of insurance coverage will be explored through interviews with patients and physicians.

7. A sample of the population with emphasis on the aged, retired, and disabled will be surveyed to determine its health experience, charges incurred, amount of insurance coverage, and current disability.

8. A study of Michigan Hospital Service and Michigan Medical Service (Blue Cross - Blue Shield) will be made specifically because of their size and breadth of program. This study will cover such factors as administration, accounting, benefits, enrollment and underwriting policies, rating principles, hospital relations, research and planning, reserves, service concept, and use of services. In Michigan Medical Service only, fee schedules and the characteristics of participating and nonparticipating physicians will also be analyzed.

STATEMENT OF THE COUNCIL

OF THE OHIO STATE MEDICAL ASSOCIATION

Regarding Unauthorized Practice of Medicine by Partnerships, Associations, Institutions, Corporations, Unlicensed Persons And the Ethical Status of Physicians Involved

ON May 16, 1957 the House of Delegates of the Ohio State Medical Association adopted the following resolution:

> "WHEREAS, there have been controversies in the United States and the State of Ohio on the corporate practice of medicine and,
>
> "WHEREAS, the definition of the corporate practice of medicine has not been defined by the Ohio State Medical Association,
>
> "BE IT RESOLVED, that the Ohio State Medical Association adopt a definition of the corporate practice of medicine for uniform application throughout the State of Ohio."

With a view of complying fully with the mandate expressed in this resolution, The Council referred this matter to the Judicial and Professional Relations Committee and the Committee on Hospital Relations for study and report. These committees have held numerous meetings during the past year with various specialists in the practice of medicine and with other groups and organizations vitally interested in the questions involved, including representatives of the Ohio Hospital Association, in order that all sides and phases of the question of corporate practice of medicine, and closely related subjects, might be fully and fairly explored and considered.

The two committees submitted a report to The Council of the Ohio State Medical Association in mid-May, 1958.

On June 8, 1958, The Council, in official session in Columbus, voted unanimous approval of the report, the complete text of which follows:

* * *

Text of Report

While the term "corporate practice of medicine" used in the strict sense refers only to the unauthorized practice of medicine by corporations whether organized for "profit" or "not for profit") the term has been quite commonly understood as connoting the unauthorized practice of medicine by a partnership, association, institution (charitable or non-charitable), corporation (profit or non-profit) or unlicensed person, through the agency of a duly licensed physician. Believing that the House of Delegates intended the development of a definition which would embrace all forms of unauthorized practice of medicine through the agency of a duly licensed physician, and which would be of assistance in the determination of the ethical status of physicians engaged in the practice of medicine under a contract or contracts with lay organizations, the Judicial and Professional Relations Committee and the Committee on Hospital Relations approached the problem with these objectives in mind.

A thorough understanding of the basic reasons for the long established rule forbidding what is popularly known as "corporate practice" is very essential to the proper understanding of the rule itself and to the determination of what activities lie within, and what activities lie without, its orbit. The ascertainment of these basic reasons, and the problem of developing a clear, understandable and workable definition have necessitated a careful examination of the legal pronouncements on the subject of corporate practice, as well as the ethical pronouncements of the American Medical Association and of this Association on the same subject. We shall, therefore, proceed to review some of the pertinent pronouncements of the legal authorities and of the AMA and the OSMA on the subject.

Allison Case

One of the leading court cases explaining the basic reasons for the rule forbidding the "corporate practice of medicine" is that of *Dr. Allison Dentist, Inc. vs. Allison,* 196 N. E. Rep. 799, decided by the Supreme Court of Illinois about 20 years ago.

In holding that the corporation could not lawfully engage in the practice of medicine the Court said:

> "The practice of a profession is everywhere held to be subject to licensing and regulation under the police power and not subject to commercialization or exploitation. * * To practice a profession requires something more than the financial ability to hire competent persons to do the actual work. It can be done only by a duly qualified human being and to qualify something more than mere knowledge or skill is essential. The qualifications include personal characteristics, such as honesty, guided by an upright conscience and a sense of loyalty to clients or patients even to the extent of sacrificing pecuniary profit if necessary. These requirements are spoken of generically as that good moral character which is a prerequisite to the licensing of any professional man. No corporation can qualify. It can have neither honesty nor conscience and its loyalty must, in the very nature of its being, be yielded to its managing officers, its directors and its stockholders. Its employees must owe their first allegiance to their corporate employer and cannot give the patient anything better than a secondary or divided loyalty."
> ** (Citation of court decisions omitted).

Ohio Attorney General Opinion

In Opinion No. 1751 of the Attorney General of Ohio, rendered on August 20, 1952, the Attorney General called attention to the fact that Section 8623-3 of the General Code of Ohio (now Revised Code Section 1701.04) prohibits the corporate practice of a profession, and he reviewed various Ohio court decisions holding that a corporation may not engage in the practice of optometry or law. In holding that the prohibition contained in the statute, and the principles announced in the Ohio court decisions, applied to medicine as fully as to optometry and law, the Attorney General made this significant statement:

> "In view of the emphasis in the Ohio decisions on good moral character as a requirement of practitioners of a profession, we must conclude that the courts regard the preservation of such requirement as the principal legislative objective of the prohibition in Section 8623-3, supra, of the corporate practice of a profession. In this view of the matter it would appear that the General Assembly entertained the notion that corporations, as impersonal entities, are amoral in character, and could not be relied upon to adhere to the canons of ethics which obtain in the several professions, especially in instances where control of the activities of the corporation is vested in individuals not licensed in the profession concerned. Accordingly, such being the legislative purpose and policy, I am wholly unable to perceive the logic of any interpretation of the 'sanitarium provision' in Section 8623-3, supra, which would permit corporations generally to engage in the practice of medicine, while at the same time all of the other professions are strictly guarded against invasion by corporate practitioners. I am the more inclined to this view for the reason, commonly recognized in both lay and professional circles, that in no profession recognized by the law as such is there a greater need for professional ethical standards of the highest sort than in the field of medicine."

AMA Principles of Medical Ethics

Justification for the rule forbidding associations, institutions, and corporations to practice medicine will also be found in the Principles of Medical Ethics and in the pronouncements of the Judicial Council of the AMA relative to the ethical factor involved in the participation by a duly licensed physician in certain types of contract practice. The 1957 Principles of Medical Ethics contain no definition of "contract practice" and make no express reference to such term. However, the Judicial Council of the AMA has expressed the opinion that Section 6 of the 1957 Principles embraces the spirit and intent of Chapter VII, Sections 3 and 5 of the 1955 edition of the Principles of Medical Ethics relating to contract practice; these Sections are as follows:

Section 6 (1957 edition):

> "A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care."

Section 3 (1955 edition):

> "Contract practice as applied to medicine means the practice of medicine under an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization, political subdivision or individual, whereby partial or full medical services are provided for a group or class of individuals on the basis of a fee schedule, or for a salary, or for a fixed rate per capita.
>
> "Contract practice *per se* is not unethical. Contract practice is unethical if it permits of features or conditions that are declared unethical in these Principles of Medical Ethics or if the contract or any of its provisions causes deteriora-

tion of the quality of the medical services rendered."

Section 5 (1955 edition):

"A physician should not dispose of his professional attainments or services to any hospital, lay body, organizations, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people."

Opinions of Judicial Council

The following are excerpts from Opinions and Reports of the Judicial Council of the AMA which are applicable in the interpretation of the above-quoted Principles of Medical Ethics:

"When a physician signs a contract with a commercial organization to make physical exabinations of all persons sent to him by the organization for a price set by the organization, and allows that organization to make its own charge to the individuals examined for the services rendered by the physician, the physician is selling his independence to the jobber.

"* * *

"Individualism in the practice of medicine is essential to success if one had in mind the interest of the patient and the encouragement of medical progress. The relation between the patient and the physician is an individual matter, and anything that disturbs this relationship is detrimental to the best interests of the patient. We cannot help but feel that the service of periodic health examinations, as conducted by commercial institutions, must inevitably result in the undermining of the confidence of the people in the ability of the practitioner." (1924 Report)

"The Judicial Council desires to express again its firm conviction that the benefits of scientific medicine cannot be adequately delivered to the individual through the medium of a third party, and that the communication of results of physical examination and the general advice with which it should be associated should go directly from the individual physician to his patients. The relation between the patient and the physician is an individual matter, and anything that disturbs this relationship is detrimental to the best interests of the patient." (1925 Report)

"It has been brought to the attention of the Judicial Council that some hospitals have adopted rules whereby attending staff physicians are prohibited, under certain conditions, from accepting fees for professional services, though charges for such services are made and fees are collected and appropriated to their own use by these hospitals. In one instance, members of a hospital staff were prohibited from the collection of fees for services rendered to certain ward patients, who were required to pay for hospital accommodations and to pay for service rendered by members of its staff, the hospital retaining all money collected for its own use. The Judicial Council gave its opinion to the effect that such procedure on the part of a hospital is unethical." (1929 Report)

"With regard to the practice of medicine by corporations, it is the opinion of the Judicial Council, that such practice is detrimental to the best interests of scientific medicine and of the people themselves. When medical service is made impersonal, when the humanities of medicine are removed, when the coldness and automaticity of the machine are substituted for the humane interest inherent in individual service and the professional and scientific independence of the individual physician, the greatest incentive to scientific improvement will be destroyed and the public will be poorly served." (1930 Report)

"The privilege of healing the sick as a profession is a right granted only to those properly qualified and licensed by the state. It is a privilege belonging only to the medical profession. It is a sacrifice of professional dignity that this exclusive right of medicine is so often sold for individual gain or its possessor deprived of it against his will. In increasing numbers, physicians are disposing of their professional attainments to lay organizations under terms which permits a direct profit from the fees or salaries paid for their services to accrue to the lay bodies employing them. Such a procedure is absolutely destructive of that personal responsibility and relationship which is essential to the best interests of the patient.

"Outstanding examples of this type of unearned gain are not difficult to find. There are insurance companies administering workmen's compensation benefits wherein the salaries or fees paid to the physician by the insurance company are so much below the legal fees on which the premium paid by the industry is based as to furnish a large direct profit to the insurance company. Certain hospitals are forbidding their staffs of physicians to charge fees for their professional services to 'house cases' but are themselves collecting such fees and absorbing them in hospital income. Some universities, by employing full time hospital staffs and opening their doors to the general public, charging such fees for the professional care of the patients as to net the university no small profit, are in direct and unethical competition with the profession at large and their own graduates. They are making a direct profit by a practice of questionable legality, from the professional care." (1932 Report)

"Many forces are pressing for the adoption of new methods of medical practice and for changes in the relations of physicians, as individividuals and as organized groups, toward the public and toward institutions and organizations, and also for revolutionary changes in the very traditions of the profession with respect to the obligations and privileges of physicians in their contacts with one another. These forces have in some instances been sadly misdirected and will result in disaster to medicine and to the public.

"The complexities of modern society may make it imperative that some changes shall be made, but the duty of the organized profession is to see to it that any and all proposals for change, from whatever source, shall be scrupulously and deliberately examined with the view of determining their ultimate value. Decisions should not be made on the basis of feasibility for the immediate present but should be made in the light of the experience of the profession, the nature of its service, the imperative need for maintaining professionalism and the absolute necessity for unhampered scientific advancement, and with the utmost regard for the best interest of the people." (1932 Report)

Section 7 of Principles

Section 7 of the 1957 Principles of Medical Ethics reads:

> "In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient."

The Judicial Council has expressed the opinion that Section 7 embraces the spirit and intent of Chapter I, Section 6, of the 1955 edition of the Principles; Section 6 of Chapter I reads as follows:

> "The ethical physician, engaged in the practice of medicine, limits the sources of his income received from professional activities to services rendered the patient. Remuneration received for such services should be in the form and amount specifically announced to the patient at the time the service is rendered or in the form of a subsequent statement.
>
> "Unethical methods of inducement to refer patients are devices employed in a system of patronage and reward. They are practiced only by unethical physicians and often utilize deception and coercion. They may consist of the division of a fee collected by one physician ostensibly for services rendered by him and divided with the referring physician or physicians or of receiving the entire fee in alternate cases.
>
> "When patients are referred by one physician to another, it is unethical for either physician to offer or to receive any inducement other than the quality of professional services. Included among unethical inducements are split fees, rebates, 'kickbacks,' discounts, loans, favors, gifts, and emoluments with or without the knowledge of the patient. Fee splitting violates the patient's trust that his physician will not exploit his dependence upon him and invites physicians to place the desire for profit above the opportunity to render appropriate medical service.
>
> "Billing procedures which tend to induce physicians to split fees are unethical. Combined billing by physicians may jeopardize the doctor-patient relationship by limiting the opportunity for understanding of the financial arrangement between the patient and each physician. It may provide opportunity for excessive fees and may interfere with free choice of consultants, which is contrary to the highest standards of medical care."

Opinions on Section 7

The following are excerpts from the Opinions and Reports of the Judicial Council of the AMA, which are applicable in the interpretation of Section 7 of the 1957 Principles:

> "There have been widespread inquiries and complaints concerning the practice of medicine by hospitals, the division of fees between hospitals and doctors, the acceptance of commissions or rebates by ophthalmologists from opticians, the extensive unethical instances of contract practice particularly in the Pacific Coast states. Concerning all of these matters it is sufficient to say that wide extent of an unethical practice does not make it ethical. Ethics has to do with principles, not numbers or locality. A procedure unthical in one part of the country cannot be ethical under the same circumstances in another. * * *

The Judicial Council deplores such ignoring of ethical principles, not only because of the extent of the practice but because in many instances the pleas of the financial necessity cannot be offered as an excuse. The Council can only publicize the abuses and express its severe condemnation of them. It has no power in itself of control or correction." (1934 Report)

"The suggestion has been made by some hospitals that physicians who utilize the hospital facilities should pay to the hospital a percentage of the fees which they receive from their patients while being cared for in the hospital.

"The Council has many times expressed itself on the subject of fee splitting. The suggested proposal is clearly a case of splitting or sharing professional fees with a lay organization which should not render professional service in the first place, but which, in addition, has already levied its regular bill for the services which it legitimately rendered." (1952 Report)

OSMA Policy Statement in 1943

The following Statement of Policy was adopted by The Council of the OSMA on October 3, 1943:

"If a hospital, a corporation, employs a physician at a fixed stipend or on a commission or percentage basis and charges and collects a fee for his professional services and retains the amount collected, regardless of whether the hospital profits or loses under such an arrangement, we are of the opinion:

"1. That an agency relationship exists between the hospital and such physician and that the familiar legal doctrine of *respondeat superior* applies, meaning that the hospital (a corporation) is responsible for the acts of such physician (its agent) and therefore is liable for the torts (wrongful acts) of the physician;

"2. That the hospital (a corporation) is itself engaged in the practice of medicine, as the hospital occupies the position of principal in an agency relationship involving the practice of medicine and, therefore, falls within the purview of the general rules of agency which establish the proposition that the principal, in effect, performs those acts which are performed by the agent;

"3. That, inasmuch as the practice of medicine by a corporation is unlawful under Ohio statutes, the hospital cannot legally practice medicine directly or **indirectly by means of an agent,** even though such agent may be a duly licensed physician;

"4. That it is unethical and unprofessional in accordance with the provisions of Article 6 of the Principles of Medical Ethics of the American Medical Association relating to contract practice for a physician to enter into an arrangement as described.

"The foregoing conclusions on the legal questions involved are based on numerous court decisions and legal opinions wherein the weight of the evidence, judicial reasoning and statutory authority favors the interpretations herein set forth.

"Some may argue that unlawful and unethical practices such as those referred to are being carried on in various communities and that no steps have been taken to stop or prevent them.

"Be that as it may, the fact that such unlawful and unethical practices are occurring, seemingly without interference, does not make such practices lawful or ethical.

"Legal processes are available to put an end to such unlawful acts on the part of a corporation and to revoke the license of a physician involved in the unlawful acts of the corporation. Ample authority is vested in a local medical society to invoke disciplinary action for violations of the principles of medical ethics on the part of a member.

"The foregong statements with respect to unlawful and unethical acts do not apply to an arrangement whereby a hospital, with the consent of a physician, undertakes to collect fees **on the account** of the physician for services rendered by him in the hospital and when the patient is notified of the amount of the professional charges and is informed that the physician's fees are being collected by the hospital in his name and for him."

Statement on Physicians and Hospitals

In the Joint Statement of Basic Principles for Ohio Physicians and Ohio Hospitals, formulated by the Committee on Hospital Relations of the OSMA and the Committee on Professional Relations of the Ohio Hospital Association appears the following basic principle:

> "4. The right of an individual to develop the terms of his services on the basis of local conditions and needs is recognized, but such contractual arrangements should in all cases ensure (a) the policy of professional incentive for the physician, and (b) progressive development of the hospital departments involved, in order that increasingly improved services to patients may be rendered. Moreover, a physician shall not dispose of his professional attainments or services to any hospital, lay body, organizations, group, or individual, by whatever name called, or however organized, under terms or

conditions which permit exploitation of the patient, the hospital, or the physician."

Reference to Attorney General Opinion

In Opinion No. 1751 of the Attorney General of Ohio, referred to above, at pages 2 and 3, the Attorney General made the following rulings:

> "1. A corporation, whether or not organized for profit, may not lawfully engage in the practice of medicine in this state.
>
> "* * *
>
> "4. A hospital corporation, whether or not organized for profit, is entitled to a fair compensation (a) for the use of technical equipment owned by it and used by a physician in the performance of professional services, and (b) for non-professional services supplied to such physician; but where such corporation enters into an arrangement with a physician whereby it receives compensation for such use and such services which is manifestly in excess of the fair value thereof, the hospital is unlawfully engaged in the practice of medicine and the physician concerned is guilty of grossly unprofessional conduct under the provisions of Section 1275, General Code."

In the course of this opinion the Attorney General said:

> "In view of these clear expressions of the law, I am bound to conclude that in this state corporations, whether or not organized and operated for profit, may not practice a profession indirectly by hiring licensed members of such profession to do the actual professional work involved."

Opinion on Interns and Residents

Shortly after the issuance of Opinion No. 1751 the Ohio State Medical Board made inquiry of the Attorney General as to whether Opinion No. 1751 should be construed as forbidding, or as rendering unlawful, the employment by hospitals of interns or residents. In answer to this inquiry, the Attorney General of Ohio issued, on October 14, 1952, his Opinion No. 1961 in which he held as follows:

> "Where graduate physicians are employed as interns or residents by a hospital under an arrangement whereby such employees (1) give medical and surgical treatment to charity patients under the supervision of hospital staff physicians, (2) give emergency medical and surgical treatment to any patient requiring it, even in the absence of the attending physician, and (3) in partial compensation for such services, such employees are permitted to receive instruction in medical and surgical practice from the several hospital staff physicians, during the course of which instruction they assist such staff physicians in the treatment of all types of patients, the hospital-employer is not engaged in the practice of medicine as defined in Sections 1286 and 1287, General Code (now Revised Code Sections 4731.34 and 4731.36)."

Opinion on Practice of Dentistry

In another opinion by the Ohio Attorney General in 1952, (Opinion No. 1717) the Attorney General issued the following pronouncements with respect to the practice of dentistry which seemingly would apply with equal force to the practice of medicine by an association, institution or corporation:

> "A parent-teacher association may employ a licensed dentist to operate a dental clinic on a purely charitable basis; but the operation of a dental clinic by such association under an arrangement whereby fees are charged and paid to the association for professional services rendered by a licensed dentist as an employee of such association would amount to a violation of Section 1320, General Code.
>
> "A corporation, whether or not partially supported by a local community Fund, is not authorized to engage in the practice of dentistry; and such corporation would be unlawfully engaged in the practice of dentistry where it has undertaken to operate a dental clinic by utilizing the professional services of licensed dentists and to charge and collect a fee for such professional services.
>
> "Under the provisions of Section 1329, General Code, a licensed dentist may not lawfully accept employment from a corporation or association of persons not licensed as dentists under the terms of which employment such employee performs professional dental services for which such corporation or association charges and collects a fee."

So far as The Council has been able to determine there have been no later opinions of the Ohio Attorney General which conflict with, or modify, the above Opinions Nos. 1717, 1751, and 1961.

Summary

Keeping in mind (a) the foregoing basic reasons for the general rule forbidding the unauthorized practice of medicine by partnerships, associations, institutions, corporations and unlicensed persons, (b) the provisions of the Principles of Medical Ethics, (c) the foregoing pronouncements of the AMA and of this Association, and (d) the opinions of the courts of Ohio and of the office of the Ohio Attorney General with respect to the practice of a profession by an association, institution or corporation, The Council has formulated a definition of the unauthorized practice of medicine which it hopes and believes will be of help to the component county medical societies and to all Ohio physicians in determining whether under a given set of facts there exists the unauthorized practice of medicine by a partnership, association, institution, corporation or lay person, and in determining whether under such facts any physician has been guilty of an unethical act in aiding or abetting, or participating in, any unauthorized practice as may be found to exist.

Conclusions

It is the opinion of The Council of the Ohio State Medical Association that the unauthorized practice of medicine occurs when a partnership (other than a partnership composed solely and exclusively of physicians), an association, an institution (charitable or non-charitable), a corporation (profit or non-profit), or an unlicensed person purveys or furnishes, or contracts or offers to purvey or furnish, the professional services of a duly licensed physician under terms, conditions, or circumstances whereby such partnership, association, institution, corporation or unlicensed person:

(1) directly or indirectly makes its or his own charge to the patient (or to any other person, partnership, association, institution or corporation claimed to be liable for the obligations of the patient) for the professional services performed by such licensed physician; or

(2) directly or indirectly obtains or retains the whole or any part of the charge or fee paid for such professional services, whether such professional charge or fee is separately billed or paid, or is included in the total charge billed by, or paid to, such partnership, association, institution, corporation or unlicensed person; or

(3) directly or indirectly participates in the division or sharing of the whole or any part of any professional fee or fees of such licensed physician; or

(4) receives payment or compensation in any form for, or derives any pecuniary gain, reward, or benefit from, the performance of the professional services of such licensed physician;

and any licensed physician who is a party to, or who aids or abets, such unauthorized practice of medicine thereby subjects himself to the charge of violating the Principles of Medical Ethics and also of violating the Ohio Medical Practice Act (Ohio Revised Code Section 4731.22).

Dr. Hudson Cited for Outstanding Service to His Community

At its annual meeting on May 16, the Academy of Medicine of Cleveland honored Charles L. Hudson, M. D., in recognition of his outstanding services to his community and the Academy of Medicine. Dr. Hudson is a Past-President of both the Academy of Medicine of Cleveland and the Ohio State Medical Association. He was awarded the following certificate:

"The Academy of Medicine of Cleveland and the Cuyahoga County Medical Society recognizes Charles Lowell Hudson, M. D., for distinguished service to the medical profession and to the community."

(Signed) Thomas D. Kinney, M. D.
President
May 16, 1958

Sixth Councilor District Schedules Postgraduate Day October 22

The Sixth Councilor District Postgraduate Day, which has met with much enthusiasm in recent years, has been scheduled for Wednesday, October 22, in Akron, Dr. Carl A. Gustafson, District Councilor, announced.

The program will consist primarily of panel discussions with sections on pediatrics, medicine, surgery and obstetrics-gynecology. So far more than 15 speakers have been contacted and have agreed to participate. All are professors in or chairmen of their respective departments in medical schools. Approximately six additional speakers have been invited and the committee is awaiting their replies.

Plans call for panels to be in session for the greater part of the day, several sessions running concurrently.

The committee on arrangements promises that this will be one of the finest programs sponsored by the Sixth District. Details will be announced later.

Chest Physicians' Pamphlet Outlines Chemotherapy

"Chemotherapy of Specific Infectious Diseases of the Lower Respiratory Tract," is the title of a pamphlet reprint from *Diseases of the Chest,* journal of the American College of Chest Physicians. The text is a report of the Committee on Chemotherapy and Antibiotics of that organization. Medical organizations or physicians interested in securing copies are invited to contact Maurice G. Buckles, M. D., 1 South Fourth St., Columbus 15.

You and Your Public . . .

Mutual Understanding of Fee Helps Maintain Good Physician-Patient Relationship

The doctor who feels he need not concern himself with the business side of his practice should ask himself:

"What if my patients felt the same way; what if they felt the matter of paying their fees is trivial?"

One of the biggest public relations problems the physician faces today is the business side of his practice. The need for concerning himself with this side of his practice is ably developed in an article in the March issue of *The Cincinnati Journal of Medicine,* written by Dr. I. C. Sharon, *Journal* public relations editor.

Dr. Sharon brings out the crux of the entire fee question by stating, "Failure of the patient to pay a medical fee is a symptom and the wise doctor will look for underlying causes. Turning an unpaid account over to a collector may be an easy way to dispose of it, but in most cases this signifies that the doctor's office has been remiss somewhere in the relationship with the patient."

Office Policies Important

If the doctor's office is remiss, then the doctor is remiss, for he should establish for his office staff policies for the staff to follow, and make certain that his policies are followed.

When the patient receives a statement, he does not think of it impersonally as a statement from the physician's office, but rather from the physician himself.

Dr. Sharon writes: "As in all other phases of medicine, prevention here is the best policy. Once there are standardized fees the physician or his assistant can tell the patient on his first or second visit what the usual charges are. In fact, when the secretary obtains the customary information in the patient's record, she might ask, 'Would you like to know what our usual charges are?' The doctor should be alerted if the patient answers that he doesn't care to know.

"Actually, aside from preventing future collection trouble, one learns much of the patient's psychological eccentricities. This preliminary discussion with the patient, usually by the assistant, follows along natural lines and not only provides much useful social service information but also defines the economic pattern for all future doctor-patient contacts.

Practical Planning Is Key

"The doctor who knows of the marginal economic case or the medical indigent case can start over-all medical planning in a practical way at the very beginning of his contact with the patient. This realistic approach prevents future embarrassment to the patient, minimizes bookkeeping in the doctor's office, and often avoids future financial prostration of the patient and his family."

Dr. Sharon presents two very relative questions to ask the person who seeks a reduced fee. One is, "Do you feel that the charge is excessive?" If the patient does not feel it is in excess, the question which follows is, "Will payment of this fee affect your standard of living within the next six months?"

These questions bring up the basic issues diplomatically, and usually develop information the physician needs to evaluate the person's ability to pay. These questions are far more tactful than a blunt "how much money do you make?"

Even after sincere efforts to reconcile a fee dispute fail, there remains a tactful path for the doctor to follow. He can suggest that the patient discuss the matter objectively with some thinking person, or with the local medical society, and at the same time he can courteously but firmly maintain his contention that the patient is being charged a reasonable fee.

Dr. Sharon concludes, "Gimmicks should not be a part of the economic aspect of the practice of medicine. Their employment lowers the dignity of the medical profession and endangers feelings of distrust and suspicion toward doctors. The practice of charging more than the doctor ordinarily expects to get, with the intent of abruptly reducing the fee if the patient complains, is unbecoming to one in the medical profession.

Need Determines Visits

"Scheduling of repeated visits in excess of what the doctor feels is required for good therapy is certainly disreputable. The use of placebos, injections, and other methods which the doctor knows are not to the patient's best welfare over the long term is deplorable.

"There should be no secrecy about lowering a fee if the circumstances warrant it. The doctor brings about disrespect for himself when he lowers a fee and then tells the patient not to mention this to anyone else. Reducing a fee only to a minor degree generally accomplishes nothing and encourages future bargaining.

"The more the doctor is able to practice sound, objective medicine, and this is determined by his psychological needs and economic pressures, the less he will need to employ gimmicks in his daily practice. What is to the best interest of the patient in the long run should determine his fees as well as his therapy. What is to the best interest to the patient is eventually best for the doctor, for the medical profession, and for society."

License Over 7,000 New Physicians in U. S.

For the fifth consecutive year more than 7,000 new physicians entered the practice of medicine in the United States during 1957.

This was revealed in the 56th annual report of the American Medical Association's Council on Medical Education and Hospitals which appears in the May 31 *Journal of the American Medical Association.*

In Ohio, the State Medical Board issued licenses to 423 graduates in medicine by examination and 318 by endorsement. The Ohio board also issued licenses to 78 osteopaths by examination and six by endorsement.

Nationally, of the 7,455 new doctors licensed to practice, 5,872 licenses were given as a result of written examination and 1,583 by interstate reciprocity or endorsement of credentials.

During the same period, 3,500 physician deaths were reported, which reduces the over-all gain in the doctor population to 3,955.

In all, state and territorial boards issued 15,090 licenses during the year but 7,635 went to doctors already holding licenses from another state or to men who took examinations in more than one state.

The total number of licenses issued, both by written examination and reciprocity or endorsement of credentials, represents an increase of 547 over 1956.

In issuing 2,167 licenses, California led all other states. New York was second with 1,355, while Ohio and Pennsylvania were next with 831 and 741 licenses respectively. Florida, Illinois, Maryland, and Texas each had in excess of 500. Nevada, with 15, licensed the fewest number of doctors.

During the year there were 9,116 applicants for licensure by written examination. Of these, 7,769 passed and 1,347 failed.

Three medical schools had graduates for the first time during the period. They were the University of Missouri, University of Saskatechwan, and the University of Mississippi. All of the graduates of the Mississippi school passed their written examinations.

The graduates of foreign faculties of medicine include both American and foreign born and the 1,345 who passed the examination represent an increase of 333 successful candidates over 1956.

Have You Reregistered Under Harrison Narcotics Act?

The Narcotics Division of the Federal Internal Revenue Service has mailed to physicians on its record the proper forms for reregistering under the Harrison Narcotics Act. Initial application for registration by the physician may be made at any time, but existing permits must be renewed each year before July 1. The fee is $1.

Physicians who have not reregistered are urged to do so immediately.

Physicians who administer, dispense or prescribe cannabis must obtain a special permit under the Marihuaha Tax Act and pay an additional tax of $1.

Report Projects 1970 Need for Registered Nurses in Ohio

Ohio will have to increase its number of registered nurses by 36,000 by 1970 in order to meet National League for Nursing standards for the population anticipated by that year, according to a report of the Division of Nursing, Ohio Department of Health.

The report revealed that the current ratio of nurses per 100,000 population in Ohio is 232, while the NLN has recommended that the ratio be increased to 300-350 per 100,000 population. By 1970, Ohio's population is expected to increase 28 per cent.

"In the 62 schools of nursing in Ohio in 1956, enrollments reached 6,300. From 1951 to 1956 (the enrollment) increased one-tenth of one per cent each year. If this rate of increase in proportion continues, enrollments can be expected to reach 12,000 by 1965—17,000 by 1970," the report states.

It also points out that the number of college age students considered potential candidates for enrollment in schools of nursing (190,000 in 1955) is expected to reach 375,000 in 1970.

The report was based on information obtained from 288 general hospitals, 125 nursing homes, 22 hospitals of the Department of Mental Hygiene and Correction, 62 professional schools and 16 practical schools of nursing.

Science Writing Workshop . . .

Representatives of the Medical Profession and Writers Interested in Medicine Get Together in Cincinnati at Jointly Sponsored Conference

MEDICINE has a story to tell, news media wants to tell the story, and the public wants to know the story. That was the consensus of participants in the Regional Science Writing Workshop in Cincinnati May 22 jointly sponsored by the AMA and the National Association of Science Writers.

And they agreed that mutual cooperation between physicians and science writers is bringing to the public accurate, informative and reliable medical news.

It further was pointed out that in almost every case where a medical story is not accurate or in good taste, there can be found a lack of cooperation either on the part of the writer, the physician or medical group, or both.

Both the science writers and the physicians asserted that cooperation has produced an understanding of "the other fellow's problem" and a greater respect and appreciation of his profession.

Ohioans on the program included Dr. George A. Woodhouse, Pleasant Hill, OSMA President; Dr. Charles L. Hudson, Cleveland, a past-president; Dr. J. Robert Hudson, president-elect, Cincinnati Academy of Medicine; Dr. Frank P. Cleveland, University of Cincinnati College of Medicine;

Dr. Lloyd Larrick, superintendent, Christ Hospital, Cincinnati; Dr. John B. Chewning, director of professional relations, Wm. S. Merrill Co., Cincinnati; Bernard C. Wexler, Ph. D., May Institute for Medical Research, Cincinnati; Dr. Benjamin F. Miller, director of medical research, May Institute; Mr. George H. Saville, OSMA director of Public Relations; Dr. George Schwemlein, editor, *Cincinnati Journal of Medicine;* Edward F. Willenborg, executive secretary, Cincinnati Academy of Medicine; Don Dunham, science editor, *The Cleveland Press;* James Golden, Jr., science editor, *The Cincinnati Enquirer.*

Also attending the workshop were Hart F. Page, assistant director of public relations, OSMA; Charles W. Edgar, administrative assistant, OSMA; Oliver W. Brown, Jr., *Dayton Daily News;* Kenneth F. Cole, city editor, *Akron Beacon Journal;* William B. Collins, reporter, *Cincinnati Enquirer;* Grant A. Drennen, Columbus Hospital Federation;

Rober W. Elwell, executive secretary, Toledo Academy of Medicine; R. F. Freeman, executive secretary, and Kenneth C. Evans, assistant executive secretary, Montgomery County Medical Society; Karl T. Finn, assistant to publisher, *Cincinnati Times-Star;* Mrs. Margaret K. Fischer, assistant public relations manager, Jewish Hospital Association, Cincinnati; James Hunkler, public relations manager, Battelle Memorial Institute, Columbus; Kornel Huvos, *Times-Star;* Mary McGarey, science writer, *Columbus Dispatch;* Sharon Moloney, science writer, *Cincinnati Post;* S. H. Mountcastle, executive secretary, Summit County Medical Society;

Louis J. Pansky and Eugene R. Porter, Cincinnati Health Department; Katherine Sullivan, science writer, *Columbus Citizen;* Glenn Thompson, executive editor, *Cincinnati Enquirer;* Richard Thornburg, editor, *Cincinnati Post,* and William Webb, executive secretary, Columbus Academy of Medicine.

The workshop also was attended by science writers from Michigan, Indiana and Kentucky.

Arrangements for the workshop were conducted by John L. Bach, director of the press relations section, Department of Public Relations, AMA, and members of his staff. It was the second in a series of workshops, the first being held in Syracuse, N. Y., and three additional sessions planned in other parts of the nation.

Grant Promotes Study in Genetics At Western Reserve

A grant of $317,165 for a genetic study headed by Dr. Arthur G. Steinberg of Western Reserve University became effective June 1.

The grant, made by the National Heart Institute of the National Institutes of Health, will be paid over a five-year period. It will be used for a study of a religious community of about 10,000 and its records which have been carefully kept for more than 100 years.

The study will include data on diet, the relationship between cholesterol and coronary disease, the incidence of diabetes, the role of heredity in the relationship of blood groups and their effect on fertility and sex ratio, and the incidence of gene mutation.

Dr. Walter H. Pritchard, associate professor of medicine, has been designated to assist Dr. Steinberg. The latter is professor of biology and assistant professor of genetics in the department of preventive medicine.

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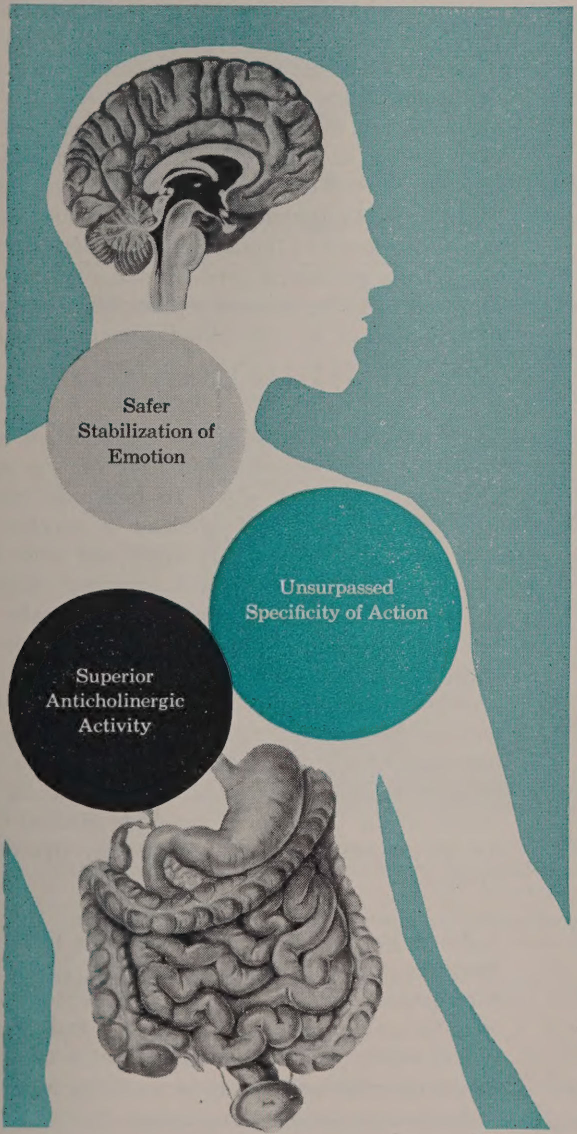

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New Medicare Policy on Drugs . . .

The Government Agency Will Pay for Drugs Administered Parenterally, But Will Not Be Responsible for Oral Medication Dispensed or Prescribed

A NEW POLICY regarding the furnishing of drugs by physicians and payment for them under the Medicare Program was issued on May 29 by the Office of Dependents Medical Care, Washington. The new policy which will become effective July 1 is as follows:

Payment for oral medication dispensed or prescribed by physicians providing care authorized under the Medicare Program to eligible dependents will be the responsibility of the patient or sponsor and will not be compensable to physicians under the Medicare Program.

Payment for Drugs Amended

Physicians furnishing authorized care to eligible dependents under the provisions of the Dependents' Medical Care Act may include the cost to them of those drugs which they administer parenterally, provided such drugs are necessary and directly related to the condition for which authorized care and treatment are being furnished.

In order for a physician to obtain reimbursement for any drug administered parenterally, he must identify the nomenclature and quantity of the drug and set forth the cost thereof to him on the Claim Form or attachment thereto. No service or breakage charge is payable.

The physician's statement as to the cost to him of drugs parenterally administered, for which reimbursement is requested, may be accepted by Fiscal Administrators without question unless, during the review of the claim involved, it appears the charge indicated thereon is not in conformity with other charges for similar drugs. It is recognized that errors may be made in billings for drugs. (For example, there may be a typographical error in recording the amount of charges.) Where the amount charged appears for any reason to be in error, discrepancies will be resolved prior to the payment of such claims. Fiscal Administrators should communicate with their State Medicare Committee or with the Office for Dependents' Medical Care, as appropriate, in unresolved or disputed cases or on matters not covered by this letter.

Claims received on or after July 1, 1958, for drug items furnished prior thereto may be paid in accordance with the policy in effect on that date.

The policy authorizing the furnishing of drugs to hospital inpatients remains unchanged.

The policy to the effect that an additional amount is not payable to a physician or surgeon who furnishes his own anesthetic equipment or materials will continue in effect.

Medicare patients may continue to obtain medication from pharmacies of uniformed services medical facilities upon prescription of a civilian physician if the items prescribed are available there or they may obtain such medication from civilian pharmacies at their own expense.

First Year of Medicare

Submitted to Congress recently was detailed report on first year of operation of Medicare, through December 31, 1957. Following are some of the highlights from the report:

Strong case is made for allowing dependents to elect civilian or military health and hospital services. To restrict freedom of choice (as House Appropriations Committee wishes to do) would impair servicemen's morale, promote deception by dependents preferring civilian care, increase administrative costs, alienate civilian physicians and be accompanied by other disadvantages, according to the report.

Indemnity Discussed

The document acknowledges that "distant rumblings for an indemnity plan have become more thunderous in some areas." In reply, the report says the program **does** embrace a number of indemnity, co-insurance, deductible and other features common to group health insurance plans.

"Despite isolated reiterations for straight indemnity by certain groups, notably leaders of organized medicine in widely separated areas, the proof of the satisfaction of the program lies with the individual physicians," it states. "During the first year of the program, there have been very few individual representations brought to the attention of the Office for Dependents Medical Care for an indemnity contract, or for any significant changes."

Statistics Listed

As of January 31, 1957, dependents living on American soil numbered an estimated 2,503,039. Air Force claimed 937,923; Army, 816,250; Navy, 562,466; Marine Corps, 139,600, and Public Health Service, Coast Guard and Coast & Geodetic Survey the remainder. Of those receiving Medicare

(Continued on Page 950)

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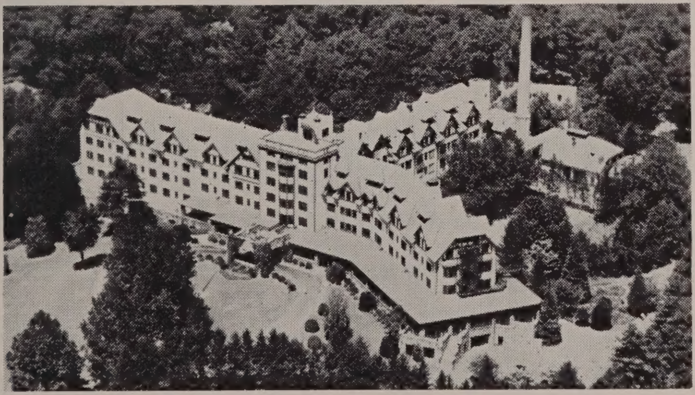

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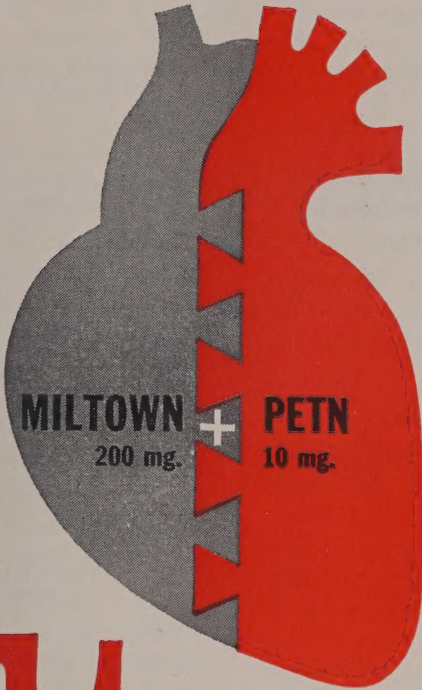
1. *Friedlander, H. S.: The role of ataraxics in cardiology. Am. J. Card.* **1***:395, March 1958.*
2. *Shapiro, S.: Observations on the use of meprobamate in cardiovascular disorders. Angiology* **8***:504, Dec. 1957.*



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Each tablet contains: 200 mg. Miltown + 10 mg. pentaerythritol tetranitrate.
Usual dosage: 1 or 2 tablets q.i.d. *before meals* and at bedtime.
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benefits, 97.9 per cent were under age 40 and 25 per cent were children under 14. Maternity cases accounted for 45 per cent of the total. Next in order was surgery (28 per cent).

Among maternity cases, 86.2 per cent culminated in normal deliveries; 2.3 per cent were complicated; 7.6 per cent were miscarriages and abortions; 3.9 per cent involved other complications of pregnancy. Military hospitals delivered 58,710 fewer babies in 1957 than in 1956.

* * *

How the Estate of a Deceased Doctor May Make Claim for Professional Services Under Medicare

The following information is from Major General Paul I. Robinson, MC, executive director, Office for Dependents' Medical Care (Medicare):

Claims for Services Rendered by Physicians or Dentists Now Deceased

1. The following requirements and procedures relating to the acceptable method by which claims for services rendered by physicians or dentists now deceased may be accepted and processed upon submission by personal representatives, executors, etc, are furnished for the information and guidance of all concerned.

2. a. In such cases, the DA Form 1863 should be executed as in other routine cases, with one exception. The certification set forth below should be accomplished by the deceased physician's or dentist's personal representative in lieu of the certification in Item 29 on the form and should be attached to the claim form:

Certification as to Services Rendered by Physician or Dentist Now Deceased

I certify that the attached statement is true and correct and that payment due from the Government under P. L. 569 has not been received; that said statement is for services which were rendered by Dr. .... as the attending physician (dentist), or, as authorized by the attending physician (dentist); that he was not an intern, a resident, or otherwise in a training status at the time he rendered the care; that, except for the amount shown in Item 26, I will accept as full payment for services rendered by him and covered by P.L. 569 the amount of his usual fee shown in Item 24, or the amount finally approved by the Government, whichever is less. Services included in these charges in Item 24 which were of unusual degree involving excessive effort are explained by the attached Special Report. My acceptance of any amount from the Government for care included in this statement and authorized under P.L 569 will preclude me from accepting any amount therefor from the patient or other source in excess of that shown in Item 24.

b. In addition, evidence should be submitted to show the signatory's status as the personal representative of the physician's or dentist's estate—e. g., letters of administration, copy of court order appointing the person as executor, or other documentary evidence of the fact that the person is the personal representative of the deceased's estate.

c. Evidence should also be submitted sufficient to corroborate the fact that the services described on the DA Form 1863 were actually performed. The physician or dentist could have stated from personal knowledge that he performed the services; the personal representative may not have knowledge of the fact. The corroboration should be by someone having actual knowledge that the services were performed by the named physician or dentist—e. g., a hospital administrator or other hospital personnel, a partner of the physician or dentist, an office assistant to the physician or dentist, or the patient involved.

Ohio Girls Place 11th, 13th in AAPS Essay Competition

Miss Jane Litzinger, Somerset, Ohio, won 11th place and Miss Janet Holshoy, Massillon, Ohio, won 13th place in the recently completed Association of American Physicians and Surgeons national essay contest. Both received $75 awards for essays on "The Advantages of the American Free Enterprise System."

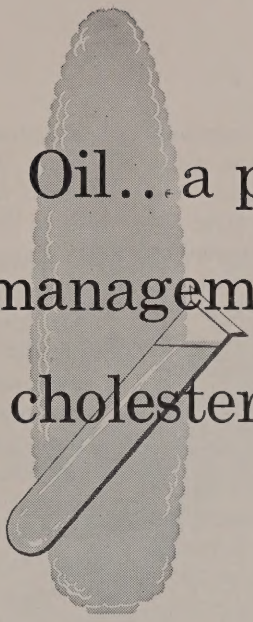
Miss Litzinger previously had placed third in the AAPS Ohio competition, while Miss Holshoy's essay was submitted directly to the national contest. Richard M. Dyer, Hiram, won first place in the Ohio contest, using the same topic. Contestants had their choice of that topic or "The Advantages of Private Medical Care."

Second place in Ohio contest was taken by Shirley Ann Wyse, Archbold. Honorable mention was given to Judy Strand, Mantua; Richard Curtis, Dover; and Cathy Ryan, Somerset.

Crippled Children Study Slated

Western Reserve University School of Medicine received a grant of $8,855 for a research project entitled, "Studies in the Immunological Factors in Homogenous Bone Transplantation." It is one of several projects sponsored by the National Society for Crippled Children and Adults promoting research in bone formation and malformation. Dr. Charles H. Herndon will direct the study at Western Reserve.

Mazola® Corn Oil…a palatable food effective in the management and control of serum cholesterol levels



Extensive clinical tests show that when the diet contains an adequate amount of Mazola Corn Oil, serum cholesterol levels tend to be normal… high blood cholesterol levels are lowered, normal levels maintained.

Fortunately for both physician and patient, Mazola Corn Oil is not only rich in unsaturated fatty acids, it is also a delicious food. It becomes an enjoyable and normal part of the patient's daily meals—no complicated or special diet is required.

Here is a therapy easy for you to prescribe, easy and pleasant for your patients to follow.

Nutritional authorities generally recommend that fats should provide no more than 30% of the total calories. In cholesterol-lowering diets from one-third to one-half of these fats should be unsaturated, such as in Mazola Corn Oil.

IN COOKING OR SALADS

Mazola Corn Oil is a superlative cooking oil as well as a delicious salad oil. Adequate amounts can be eaten daily—in a wide variety of salad dressings and in a great number of fried and baked foods.

MOST EFFECTIVE

Pure, clear, bland and odorless. Mazola Corn Oil is stable and dependable, providing the full measure of cholesterol-lowering unsaturated fatty acids characteristic of corn oil.

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For a 3000 calorie diet	2.5 tablespoonsful
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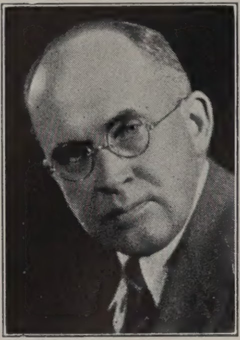

C. L. Cummer, M. D.

Clyde L. Cummer, M. D., Cleveland, outstanding physician and Past-President of the Ohio State Medical Association, died on June 7 at the age of 76. Dr. Cummer served the State Association over a period of many years. He was first elected Councilor of the Fifth District in 1927; was named President-Elect in 1932 and served as President in 1933-1934.

Dr. Cummer was a graduate of Western Reserve University School of Medicine, Class of 1907. He was a member of the Ohio State Medical Association, the American Medical Association, the American Dermatological Association and American Academy of Dermatology and Syphilology; diplomate of the American Board of Dermatology and Syphilology.

From 1909 to 1946 Dr. Cummer was on the teaching staff of Western Reserve University School of Medicine, for many years as assistant clinical professor of dermatology and syphilology. He was president of the Academy of Medicine of Cleveland in 1923 and served the Academy in many other ways. He was also an early member of the Cleveland Medical Library Association and was secretary of the committee which erected its building in 1926. He was chairman of its trustees from 1927 to 1937 and was its president in 1941.

During World Wars I and II he was on the advisory medical boards for Selective Service and during the Korean Conflict was a member of the board of medical appeals for the northern district of Ohio. Other organizations with which he was affiliated included several professional fraternities, the Pasteur Club of Cleveland, the Cleveland Dermatology Society, the Sons of the American Revolution, the Union, University, Hermit and Rowfant Clubs and the Ohio Historical Society. He was author of more than 50 professional articles. Surviving are his widow, a son and a daughter.

Robert V. Anderson, M. D., Springfield; Indiana University School of Medicine, 1926; aged 56; died May 18; former member of the Ohio State Medical Association and the American Medical Association. Dr. Anderson began his practice in North Lewisburg where he remained until he moved to Springfield in 1941. He was in private practice there until five years ago when he became industrial medical officer at Wright-Patterson Air Force Base. He was a member of the Presbyterian Church. Surviving are his widow, a son, three daughters, his mother and a brother.

Lawrence N. Atlas, M. D., Laguna Beach, California; Western Reserve University School of Medicine, 1930; aged 51; died May 19; former member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons. Dr. Atlas practiced for about 20 years in Cleveland and for a number of years was chief clinical instructor in surgery at Western Reserve. He moved to California about six years ago. Surviving are his widow, a son, a daughter and a sister.

John Edwin Brown, Jr., M. D., Columbus; Harvard Medical School, 1929; aged 55; died June 3; member of the Ohio State Medical Association, the American Medical Association and the American Academy of Pediatrics; diplomate of the American Board of Pediatrics. Dr. Brown had been a practicing physician in Columbus since the completion of his medical training. A member of Columbus Academy of Medicine since 1934, he was serving at the time of death as chairman of the Academy trustees and was a member of the Academy council. He was associate professor of pediatrics at Ohio State University and his career included service in the Army Medical Corps from 1941 to 1945. He was a member of the Episcopal Church, several professional fraternities, the Rocky Fork Country Club, Medical Forum and Medical Review Club. Surviving are his widow, a daughter, two sons and his father, Dr. John E. Brown, Sr., retired physician.

Albert I. Civins, M. D., Cleveland; University of Wooster, Medical Department, Cleveland, 1901; aged 81; died April 16; former member of the Ohio State Medical Association; recipient of the OSMA 50-Year Award. Dr. Civins had been a practicing physician in the Cleveland area for 55 years. He was a member of the Temple and B'nai B'rith. Surviving are his widow and a daughter.

Pasquale G. Damiani, M. D., Peru, Indiana; Hahnemann Medical College and Hospital of Philadelphia, 1925; aged 58; died May 21. Dr. Damiani practiced for a number of years in Cleveland before he moved to Indiana about five years ago. His widow and a daughter survive.

Jerome S. Frankel, M. D., Cleveland; Ohio State University College of Medicine, 1941; aged

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45; died June 1; member of the Ohio State Medical Association, the American Medical Association, the American College of Allergists; Fellow of the American College of Physicians; diplomate of the American Board of Internal Medicine. Holder of both an M. D. and Ph. D. degrees, Dr. Frankel was director of education for Mt. Sinai Hospital and head of the Personnel Health Clinic. He was a founding member of the American Board of Clinical Chemistry; member of the American Association for the Advancement of Science, the Cleveland Diabetes Society, the American College of Allergy and the American College of Cardiology. Surviving are his widow, two sons, a daughter, his parents, two brothers and a sister.

Mose S. Griffith, M. D., Galesburg, Ill.; Miami Medical College, Cincinnati, 1907; aged 75; died May 4; former member of the Ohio State Medical Association. Dr. Griffith practiced in Batavia before World War I. He is survived by his widow and a sister.

Edwin A. Hannum, M. D., Birmingham, Michigan; University of Wooster, Medical Department, Cleveland, 1904; aged 85; died May 22; member of the Ohio State Medical Association through 1950. Dr. Hannum practiced medicine for 47 years in Cleveland before he retired and moved to Michigan. He is survived by his widow, and three sons.

Stephen S. Hudack, M. D., Enumclaw, Wash.; Western Reserve University School of Medicine, 1929; aged 57; died May 13; member of the Ohio State Medical Association through 1956. A physician in Cleveland for many years, Dr. Hudack retired last year as assistant clinical professor of surgery at Western Reserve and as head of the Department of Surgical Research and senior associate in the Department of Orthopedic Surgery at St. Luke's Hospital. He was former associate professor of orthopedic surgery at Columbia University and in World War II served as Navy lieutenant commander. He was a member of the American Association for the Surgery of Trauma; Fellow of the American College of Surgeons and member of the American Society for Experimental Pathology. Surviving are his widow, three brothers and two sisters.

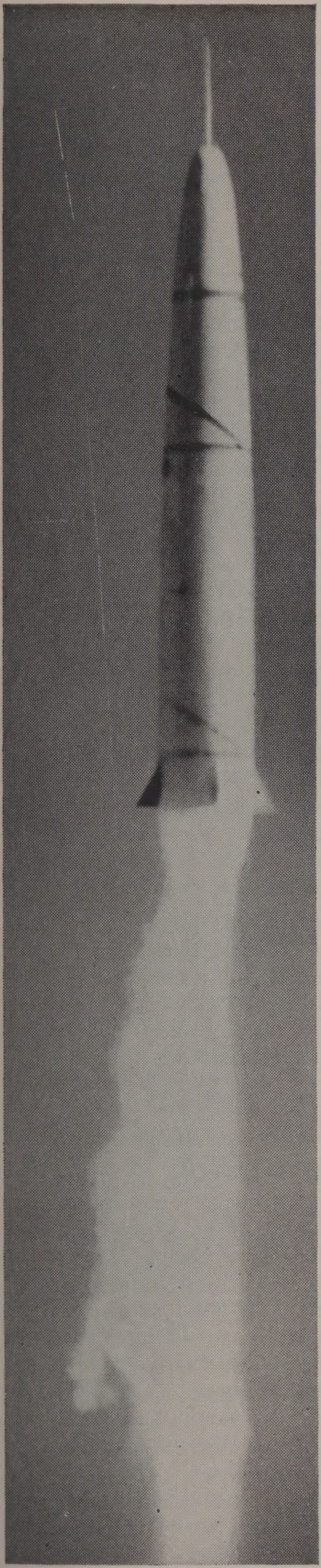
Ruth A. Koons Pereny, M. D., Columbus and Westerville; Ohio State University College of Medicine, 1930; aged 52; died June 9; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Physicians. Dr. Koons practiced for many years in Columbus under her professional name. She was assistant professor of medicine (cardiology) at Ohio State University College of Medicine. Surviving are her husband, Andrew Pereny, and a sister.

Loyal E. Leavenworth, M. D., Canton; Western Reserve University School of Medicine, 1914; aged 69; died May 20; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons; diplomate of the American Board of Obstetrics and Gynecology. Dr. Leavenworth's entire professional career was served in Canton, with time out for service with the Navy Medical Corps during World War I. He was an active participant in the work of the Stark County Medical Society; was a past-president and former secretary of that organization and worked as member or chairman of numerous local committees; he also was a former delegate of the Society to the OSMA. He was equally active in many local civic affairs; was one of the earliest promoters of the Boy Scout movement; was active in the Canton Art Institute; he was a vestryman in the Episcopal Church; member of the Canton Club, the Chamber of Commerce, the Brookside Country Club and the YMCA. Surviving are his widow and two sons, one of whom is Dr. David Leavenworth, also of Canton.

Arthur B. McConagha, M. D., Lafayette, California; Ohio State University College of Medicine, 1909; aged 81; died May 15; member of the Ohio State Medical Association and the American Medical Association. Dr. McConagha practiced for many years in Columbus before his retirement in 1954. He formerly practiced in Ashley and Worthington. Affiliations included memberships in the Presbyterian Church and several Masonic bodies. His widow, a son, a brother and two sisters survive.

Francis E. Merritt, M. D., Barberton; Ohio State University College of Medicine, 1934; aged 48; died May 21; former member of the Ohio State Medical Association. Dr. Merritt had only recently opened an office in Barberton. He previously practiced in Akron and Amherst. Surviving are his widow, two daughters and a son.

William Mithoefer, M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1897; aged 87; died May 26; member of the Ohio State Medical Association, the American Medical Association, American Academy of Ophthalmology and Otolaryngology, American Laryngology, Rhinology and Otology Society and the American Otological Society; Fellow of the American College of Surgeons; diplomate of the American Board of Otolaryngology. A native of Cincinnati, Dr. Mithoefer served all of his professional career



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there with time out for study in New York and abroad. He was active in the affairs of the Academy of Medicine of Cincinnati and was a past-president of the society. He also was a member of the Masonic Lodge. Surviving are his widow, three sons, three daughters and a sister.

Carl Clyde Nohe, M. D., Akron; University of Maryland Medical School, 1917; aged 65; died May 17; member of the Ohio State Medical Association and the American Medical Association; delegate of the Summit County Medical Society to the OSMA from 1952 to 1958; member of the OSMA Committee on Chronic Illness; editor of the Summit County Medical Society Bulletin for a number of years. Dr. Nohe began his practice in Akron after serving in the Army Medical Corps during World War I. His practice was supplemented by years of devotion to professional organization work. Survivors include his widow, three brothers and two sisters.

Clovis H. Phillips, M. D., Cleveland; University of Cincinnati College of Medicine, 1928; aged 54; died May 29; member of the Ohio State Medical Association through 1957; former member of the American Medical Association; diplomate of the American Board of Obstetrics and Gynecology. Dr. Phillips practiced his specialty for many years in Cleveland and was assistant clinical professor of obstetrics and gynecology at Western Reserve. He is survived by his widow and two sons.

James Earl Quigley, M. D., Edinburg; University of Maryland School of Medicine, 1911; aged 74; died May 13. Dr. Quigley was living in retirement in Edinburg after practicing for years in Butler, Pa. A brother with whom he resided and two sisters survive.

Philip W. Rieg, M. D., Lake Worth, Florida; Toledo Medical College, 1913; aged 71; died May 31; former member of the Ohio State Medical Association and the American Medical Association. Dr. Rieg practiced for many years in Toledo before his retirement about 10 years ago. His widow and a son survive.

Charles A. Simpson, M. D., Cleveland; Meharry Medical School, 1927; aged 62; died June 4. Dr. Simpson practiced for many years in Cleveland. He is survived by his widow and a son.

Emmet L. Thomas, M. D., Cleveland; Eclectic Medical College, 1918; aged 70; died May 16. Dr. Thomas practiced medicine for about 40 years in Cleveland. He was a member of the Masonic Lodge, the Compass Club and Sigma Pi. Surviving are his widow, a daughter and two brothers.

Fred R. Thompson, M. D., Massillon; University of Illinois College of Medicine, 1920; aged 65; died May 15. Dr. Thompson was assistant superintendent of the Massillon State Hospital, a post which he held since 1949. During World War II, Dr. Thompson served in the Navy Medical Corps, and before the war conducted a private practice in Columbus. Affiliations included memberships in the Methodist Church and the Lions Club.

David A. Tucker, Jr., M. D., Cincinnati; University of Cincinnati College of Medicine, 1916; aged 67; died June 3; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Physicians; diplomate of the American Board of Internal Medicine. Dr. Tucker began practice in Cincinnati after completing World War I service in France. He retired more than a year ago because of illness. For 40 years Dr. Tucker was on the faculty of the University of Cincinnati College of Medicine as professor of the history of medicine and assistant to the dean. His library on medical history will be given to the University. Over a long period of time Dr. Tucker contributed many articles to the Historian's Notebook section of *The Journal.* A past-president of the Academy of Medicine of Cincinnati, he was active in many affairs of the society. Other affiliations included memberships in Sigma Xi, Alpha Omega Alpha, the University Club and Cincinnati Country Club. Survivors include his widow and two sons.

Sigmund Wolf, M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1909; aged 73; died May 14; former member of the Ohio State Medical Association. A native of Cincinnati, Dr. Wolf served all of his professional career there. He is survived by a sister and a brother.

New Movie Is Available on Social Security

The Chamber of Commerce of the United States has announced availability of a new 26-minute movie entitled "A Matter of Choice—What Everyone Should Know About Social Security."

This free 16-mm sound film points up the fact that American leaders and adults in all walks of life, as well as high school students, hold beliefs about Social Security which are founded more on fancy than on facts. "A Matter of Choice" clarifies some of the fundamentals of social security and of individual freedom of choice.

Requests for bookings should be sent direct to: Modern Talking Picture Service, 3 East 54th Street, New York 22, N. Y.

Georgia Dispute Settled . . .

Agreement Is Reached by Physicians in Private Practice, Medical School And Talmadge Memorial Hospital on Admissions, Disposition of Fees, etc.

AN intra-professional dispute which has been taking place in Georgia for several years, revolving around the administrative and operation policies of the Medical College of Georgia and the Eugene Talmadge Memorial Hospital, apparently has been settled.

The House of Delegates of the Georgia Medical Association, meeting recently, adopted a statement of agreement, culminating five years of negotiations between representatives of that association, the Richmond County Medical Society, the medical school and Talmadge Hospital.

Following is the text of the policy statement as adopted by the Georgia House of Delegates and as published in *The Journal of the Georgia Medical Association:*

Liaison Committee

It was agreed that a liaison committee would be established to be constituted as folows. The district medical societies shall propose two names each and the Medical College of Georgia is to choose one name of the two. One member from each of the ten districts will provide ten members of the Liaison Committee. In addition, the Liaison Committee shall include an Executive Committee of two members of the Richmond County Medical Society to be chosen by RCMS, two members from the Medical College of Georgia to be chosen by the Medical College, and one member of the Medical Association of Georgia who resides outside of Richmond County, to be chosen by the Council of the Medical Association of Georgia. The full fifteen-man Committee shall meet once every six months. The Executive Committee, the Chairman of which shall be the MAG representative, shall meet as often as necessary and shall have power to deal with all matters subject to report to the full Liaison Committee.

Admissions

It is not and shall not become the policy of the Medical College of Georgia and the Eugene Talmadge Memorial Hospital to enter into the competitive practice of medicine. Admission of patients of unusual teaching interest shall be favored. It is realized, however, that emergencies and unusual circumstances will arise in which patients who are not indigent will require the services of these institutions. No other pay (private) patients shall be admitted. This policy shall apply to both in and out patients.

The term "unusual circumstances" shall be understood to apply to those patients whose problems in the opinion of their referring doctor can be especially appropriately cared for at the Eugene Talmadge Memorial Hospital. Any question or controversy arising will be referred to the Liaison Committee in writing for the Committee's consideration.

No patient may be accepted by the institution except by proper referral of his *regular physician.*

Pay (private) patients admitted under the category of emergencies without referral by a doctor should be discharged or transferred from the Eugene Talmadge Memorial Hospital when and if their condition permits.

Disposition of Professional Fees

Faculty members providing professional services to patients of the Hospital shall determine the charges for such services. The fees paid to the faculty members for such professional services may be paid into a special research fund. This special research fund shall not accrue to the general budget of the Board of Regents, Eugene Talmadge Memorial Hospital, or the Medical College of Georgia. Such special fund shall be used exclusively to defray the cost of medical research projects.

The faculty of the Medical College of Georgia shall determine the character and extent of such medical research projects to be supported by these funds. There shall be no contractual obligation between the Medical College of Georgia and its faculty members to pay such professional fees into the special Research Fund.

Public Relations

Publicity emanating from the Medical College of Georgia and the Eugene Talmadge Memorial Hospital shall be in good taste and consistent with the standards of the American Medical Association and the standards set by the Liaison Committee.

Vincent—Now in his 62nd year of medical practice, Dr. Harry W. Hill was the subject of an article in the magazine section of *The Dayton Daily News'* Sunday edition, recently. He holds an OSMA 50-year pin and graduated from Starling Medical College in 1894.

Short Course in Heart Disease Offered At University of Cincinnati

A postgraduate course entitled "Heart Disease—Current Concepts in Diagnosis and Treatment," will be presented by the University of Cincinnati, September 3-6.

The course will be under direction of Dr. Johnson McGuire, professor of medicine and director of the Cardiac Laboratory, University of Cincinnati, and will provide a review of recent advances in various aspects of heart disease. The faculty for the course has been selected from the Departments of Medicine, Radiology and Surgery of the College of Medicine.

The program will consist of lectures and panel discussions. Informal question and answer sessions have been planned in conjunction with the lectures and patient presentations.

Advance registration is requested. Tuition fee is $75. The course will be limited to the first 50 applicants. Applications should be sent to: Johnson McGuire, M. D., Cardiac Laboratory, B-4, Cincinnati General Hospital, Cincinnati 29.

The program is as follows:

Wednesday, September 3

9:00 **Physical Examination of the Cardiac Patient,** Noble O. Fowler, M. D.

10:00 **Heart Sounds and Murmurs,** Ralph Shabetai, M. D.

10:30 **Acute Rheumatic Fever,** Samuel Kaplan, M. D.

11:00 **Management of Cardiac Arrhythmias,** Harold Kotte, M. D.

2:00 **Panel on Cardiac Arrhythmias,** Drs. Johnson McGuire, Harold Kotte, Noble Fowler, Robert Helm.

3:00 **Bacterial Endocarditis,** Morton Hamburger, M. D.

3:30 **Hypertension in the Pulmonary Circulation,** Noble O. Fowler, M. D.

4:00 **Cor Pulmonale,** Remo DiSalvo, M. D.

4:30 **Pulmonary Function Tests,** Ralph C. Scott, M. D.

Thursday, September 4

9:00 **Coronary Artery Disease,** Johnson McGuire, M. D.

10:00 **Diagnostic Procedures in Hypertension,** Albert Brust, M. D.

10:30 **Ocular Fundi in Hypertension and Systemic Diseases,** Albert Brust, M. D.

11:00 **Reversible Systemic Hypertension,** Remo DiSalvo, M. D.

2:00 **Panel on Hypertension,** Drs. Johnson McGuire, Albert Brust, Remo DiSalvo.

3:00 **Management of Congestive Heart Failure,** Robert A. Helm, M. D.

4:00 **Electrolyte Disturbances in Cardiac Patients,** Harvey Knowles, M. D.

4:30 **The Heart in Endocrine Disorders and Avitaminosis,** Richard Vilter, M. D.

Friday, September 5

9:00 **Common Forms of Congenital Heart Disease,** Samuel Kaplan, M. D.

10:00 **Diagnostic Procedures in Congenital Heart Disease,** Samuel Kaplan, M. D.

11:00 **Surgical Aspects of Congenital Heart Disease,** James Helmsworth, M. D.

2:00 **Panel on Congenital Heart Disease,** Drs. Samuel Kaplan, James Helmsworth, Noble Fowler, Bernard Schwartz, Ralph Shabetai.

3:00 **Surgical Aspects of Acquired Heart Disease,** Leonard Gottesman, M. D.

3:30 **Diseases of the Aorta,** Virgil Hauenstein, M. D.

4:00 **Peripheral Vascular Disease,** Arnold Iglauer, M. D.

4:30 **Surgical Treatment of Diseases of the Aorta and Peripheral Arteries,** Alfred Keirle, M. D.

Saturday, September 6

9:00 **Radiology as a Diagnostic Aid in CV Disease,** Benjamin Felson, M. D.

10:00 **The Electrocardiogram as an Aid in Diagnosis and Management of Heart Disease,** Robert A. Helm, M. D.

11:00 **The Ballistocardiogram,** John R. Braunstein, M. D.

11:30 **Pericarditis,** Johnson McGuire, M. D.

Do You Know? . . .

Dr. Fred W. Dixon, Cleveland, Past-President of the Ohio State Medical Association, has been elected president of the American Laryngological Association for 1958-1959.

* * *

In recognition of his distinguished service in the fields of prevention of blindness and preservation of sight, the honorary degree of Doctor of Science was conferred on Dr. Claude S. Perry, Columbus, by Ohio Wesleyan University at its 114th Commencement June 9 at Delaware.

* * *

Dr. Thomas E. Rardin, Columbus, is the new president-elect of the Medical Alumni Association, Ohio State University. He was named to that post at the recent fifth annual reunion of the association. Dr. Robert J. Murphy was re-elected secretary.

Buckeye News Notes . . .

Bellefontaine—The blood donor program and its role in the community was discussed by Dr. Charles Browning before the Parent-Teachers Association.

Bryan—The Mothers' Club heard Dr. John P. Kemph, Lima, speak on "Discipline and Your Child."

Cincinnati—Dr. Edward A. Gall, professor of pathology and chairman of that department at the University of Cincinnati College of Medicine, recently completed a three-week lecture-consultant tour in Peru at the invitation of several medical groups and schools there.

Defiance—A demonstration of therapeutical hypnotism was given for members of the Child Conservation League by Dr. Robert J. Blough, of Deshler.

Delaware—Dr. Robert A. Vogel, former health commissioner for Delaware, Union, Madison and Morrow Counties, June 1 assumed the $20,000 a year post as Montgomery County health commissioner.

Fremont—Slides taken during his recent trip to the Orient were shown by Dr. Frank L. Moore at a special meeting of Ottawa County registered nurses.

Galion—Dr. Mart L. Helfrich, city health commissioner, has been accorded the Community Hospital Board of Trustees Distinguished Service Award.

Lima—Dr. Charles L. Steere attended the 50th reunion of his Northwestern University School of Medicine Class of 1908 in Chicago last May.

Massillon—Dr. Jeannette C. Miller on May 20 marked the beginning of her 51st year of practicing medicine in this city. She graduated from the Cleveland College of Physicians and Surgeons (now WRU) in 1908.

Orrville—Dr. E. J. Feltes was guest speaker at the Wooster Lions Club meeting, his subject being medical hypnosis.

Perry—The Perry PTA Preschool unit heard an address on safety by Dr. Robert Irvin.

Port Clinton—For his work as medical officer at the Erie Ordnance Depot, Dr. Lester N. Bates, Fremont, has been given an award for superior professional service.

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Activities of County Societies . . .

First District

(COUNCILOR: CHARLES W. HOYT, M. D., CINCINNATI)

BUTLER

On May 28, a joint meeting of the Butler County Medical Society and the Butler County Bar Association was held. Principal speakers were Dr. Samuel R. Gerber, coroner of Cuyahoga County, Cleveland, and Dr. Frank P. Cleveland, Cincinnati pathologist and assistant coroner of Hamilton County.

HAMILTON

Dr. Clyde S. Roof, Cincinnati, has been elected president-elect of the Cincinnati Academy of Medicine. He will take office in September of 1959. Dr. J. Robert Hudson, current president-elect, will take over as president this September, succeeding Dr. George X. Schwemlein, retiring president.

Other new officers include: Dr. Ralph S. Grace, secretary; Dr. John A. Fisher, treasurer; Dr. Herbert J. Brinker, three-year trustee; Dr. Elmer R. Maurer, three-year councilman-at-large.

Delegates elected for a three-year term are Drs. Lester J. Bossert, Joseph G. Crotty, William A. Moore, Charles A. Sebastian and Daniel V. Jones. Alternate delegates include Drs. Robert A. Bader, Chapin Hawley, Donald L. Jacobs, John H. Payne, Carl F. Schilling and Edward Woliver.—*Cincinnati Post.*

Second District

(COUNCILOR: R. DEAN DOOLEY, M. D., DAYTON)

DARKE

Dr. J. A. Mendelson, superintendent of the Dayton State Receiving Hospital, was guest speaker at the May 20 meeting of the Darke County Medical Society in Greenville.

MONTGOMERY

Members of the Montgomery County Medical Society were guests at Wright-Patterson Air Force Base for the May 28 meeting. Speaker was Col. R. R. Hesberg, chief of the biophysics branch of the Aero Medical Laboratory.

At the election, Dr. E. Wallace Smith, was named president-elect for 1959. New officers assume their posts on January 1. Other officers elected are: Dr. H. A. Bremen, vice-president; Dr. N. F. Stambaugh, secretary; Dr. P. A. Eckert, treasurer; Dr. L. E. Rausch, trustee; Dr. J. G. Tye, delegate; Dr. J. W. Priest, alternate delegate. Current president is Dr. A. V. Black. He will be succeeded on the first of the year by Dr. A. J. Carlson.

Third District

(COUNCILOR: FLOYD M. ELLIOTT, M. D., ADA)

ALLEN

Dr. Leonard L. Loushin, Department of Medicine, Cleveland Clinic, was speaker at the meeting of the Lima and Allen County Academy of Medicine on May 20 in the Shawnee Country Club, Lima. His topic was, "Signs that Aid in the Recognition of Functional Disease." Approximately 80 persons attended.

HARDIN

The regular meeting of the Hardin County Medical Society was held on May 13 at Memorial Hospital, Kenton. The speaker for the evening was Dr. Robert J. Izant, Jr., of Children's Hospital in Columbus. His topic was "The Acute Abdomen in Children."—William F. Blinkley, M. D., Secretary-Treasurer.

HANCOCK

Guest speaker at the May 20 meeting of the Hancock County Medical Society in Findlay was Dr. William G. Myers, research professor of medical biophysics at Ohio State University. He described progress that is being made in the use of radio-isotopes in the medical fields. The dinner meeting was held at the Elks Home.

LOGAN

Dr. F. R. Grogan of Urbana addressed the Logan County Medical Society in May on the topic, "Symptoms, Diagnosis and Treatment of Inhalant Allergy."

SENECA

The Seneca County Medical Society held a dinner meeting on May 20 at the Country Club, Fostoria. There were 18 doctors in attendance to hear the program given by Cleveland doctors on heart surgery and surgery of the large blood vessels.—*Fostoria Review Times.*

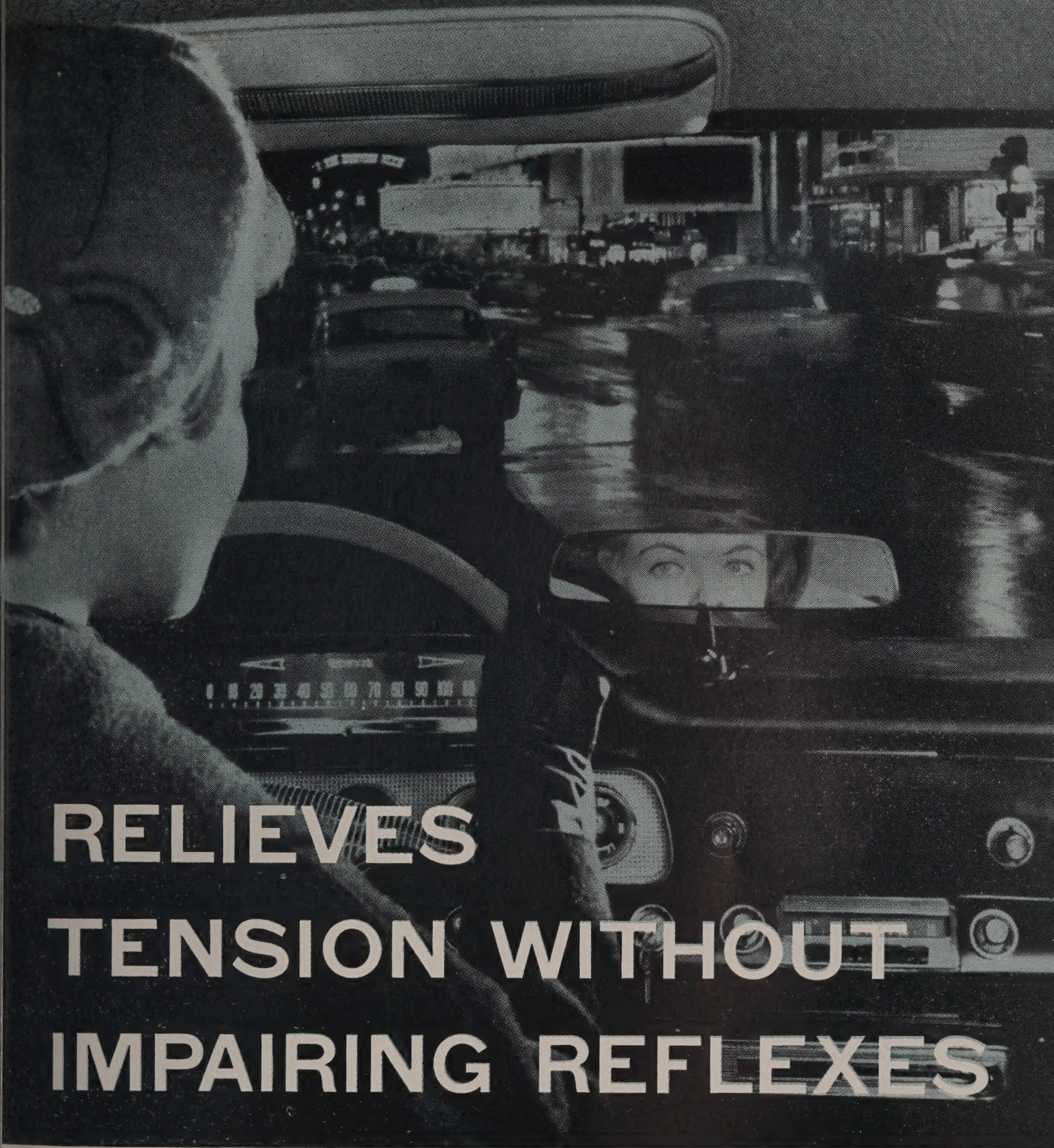
Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

PUTNAM

April meeting of Putnam County Medical Society was held at Dumont Hotel, Ottawa, April 1.

Dr. Paul F. Orr, councilor for Fourth District, addressed the meeting on the subject "Social Security for Physicians." Dr. Orr's talk included a detailed analysis of advantages and disadvantages of participation in the Social Security program. He pointed out that the compulsory feature is contrary to the life-long traditions and thinking of



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**Marquis, D. G., Kelly, E. L., Miller, J. G., Gerard, R. W. and Rapoport, A.: Ann. New York Acad. Sc. 67: 701, May 9, 1957.*

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most medical men; that it is not insurance; that it is a poor buy for most younger and middle-aged doctors. He cited the example of Sandusky County Society, whose members, after endorsing the plan 100 per cent, later reversed themselves and polled 100 per cent against it.

A discussion followed, after which Putnam Society turned down the proposal by a 90 per cent majority.—H. N. Trumbull, M. D., Corespondent.

SANDUSKY

A series of lectures for members of the Sandusky County Medical Society was given in connection with Medical Education Week in April. Lectures were given by members of a team from Wayne University College of Medicine, Detroit. The team consisted of Drs. Arnold Axelrod, Nathan S. Brooks and Harold L. Fachnie.

The afternoon program at the Fremont Federation Home was followed by dinner and an evening program.

Fifth District

(COUNCILOR: GEORGE W. PETZNICK, M. D., CLEVELAND)

AUGLAIZE

Doctors of the Auglaize County Medical Society were entertained by the Woman's Auxiliary at a meeting on May 4 at the Country Club, Wapakoneta. Mrs. Fred Bettelini showed pictures and spoke of her visit to the Doctor Schweitzer Mission in French Equatorial Africa.

CUYAHOGA

The Academy of Medicine of Cleveland named Dr. Eugene A. Ferreri, Shaker Heights, as president-elect at the May election. He will take office as president in 1959.

Incoming president is Dr. Chester R. Jablonoski, who succeeds Dr. Thomas D. Kinney. Other officers are: Dr. Harry A. Haller, Jr., vice-president; Dr. B. B. Sankey, re-elected secretary-treasurer.

New trustees are Dr. Donald B. Cameron, Dr. E. Peter Coppedge, Jr., Dr. Robert M. Eiben, Dr. Pasquale A. Ferrara, Dr. John H. Nichols, Dr. John D. Osmond, Jr., Dr. Russell P. Rizzo and Dr. William Sinclair, Jr.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

COLUMBIANA

Dr. R. B. Trunbull, Jr., Department of Surgery, Cleveland Clinic, was speaker at the May 20 meeting of the Columbiana County Medical Society in Lisbon. His topic was "Staphylococcic Infections in Hospital Practice."

MAHONING

Mahoning County Medical Society members May 20 approved recommendations of their execu-

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*Chappel, C.C., J.A.M.A., 162: 1414, (Dec. 8) 1956

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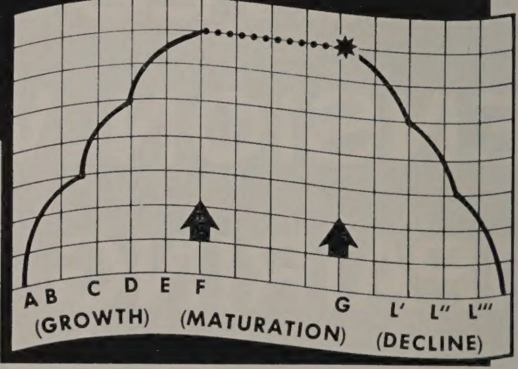

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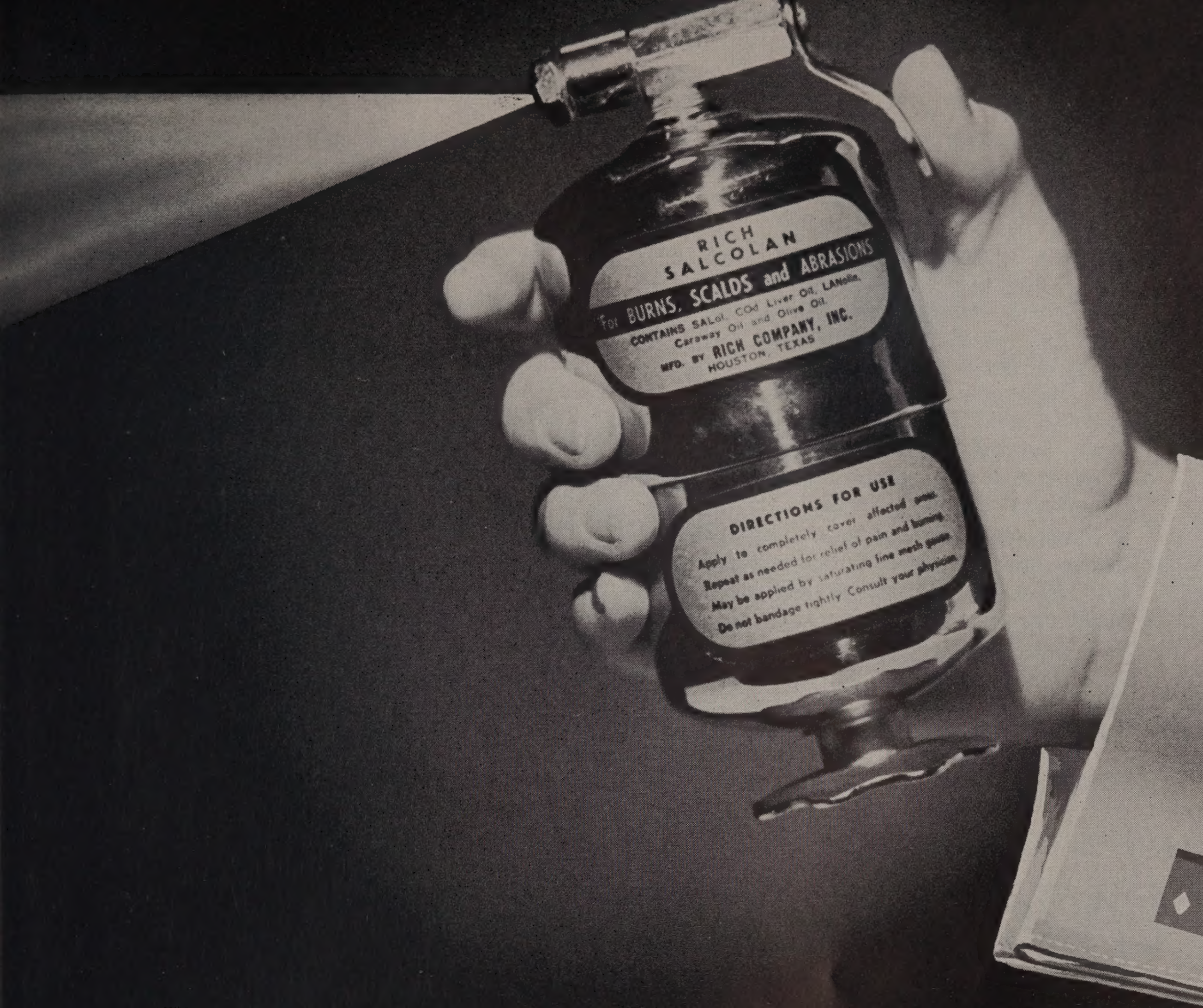
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tive and polio committees to give free third polio shots in their offices to children who already received the first two shots in mass immunization in the public and parochial schools.

The members also will continue to give polio shots in their offices to all persons 40 or under free of charge, where they are unable to pay. The action was taken at a special meeting at Tippecanoe Country Club.

Dr. Genevieve Delfs, chairman of the polio committee and Dr. A. A. Detesco, president of the society, say this is the recommendation of the American Academy of Pediatrics, which has made a thorough survey of the situation . . .

The medical society also hopes to have polio vaccination made a prerequisite for school entrance, Dr. Detesco said, and will act on this shortly. This would mean that a growing army of children would have these shots each year, along with smallpox, diphtheria and other vaccinations, now rated routine.

It was voted to boost membership dues from $30 to $75 annually, employ a qualified executive secretary and take some of the work load off the officers, busy physicians who do not have the time for it.

The meeting had the largest attendance in recent months and lasted 3½ hours as committee reports and other matters were discussed.—*Youngstown Vindicator.*

SUMMIT

"Anesthesia;New Hazards Added to Old," was the topic discussed at the June 3 meeting of the Summit County Medical Society. The speaker was Dr. Jay J. Jacoby, director of the Department of Anesthesiology, Ohio State University.

TRUMBULL

The Trumbull Country Club, Warren, was the scene of the final spring meeting of the Trumbull County Medical Society and Auxiliary on May 21. Headlining the evening's program of entertainment was John Frye and his hocus-pocus review.

The Society sponsored a blood donor day on June 6 in the Trumbull Memorial Hospital. It

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*Sea food—source of highly potent allergens. Typical are: lobster; tuna; sturgeon roe; fish oil used to prepare leather, chamois, soaps; cuttlefish bone for polishing material and tooth powder; glues made from fish products.

was recommended that each member give blood, or, if unable to do so, request that some member of the family, office staff or friend make the donation.

Eighth District

(COUNCILOR: WILLIAM D. MONGER, M. D., LANCASTER)

ATHENS

The Athens County Medical Society met for the May program in the Mount St. Mary Hospital, Nelsonville, and heard a talk by Dr. Richard Welch on "Radiological Subjects."

A committee headed by Dr. Eleanora Schmidt and including Dr. A. A. Baldwin and Dr. William Allen, Jr., was appointed to administer a scholarship fund for prospective nurses from Athens County schools.

MUSKINGUM

The Muskingum County Pharmaceutical Association was host to members of the Muskingum County Medical Society on May 20.

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

SCIOTO

The Scioto County Medical Society met on June 9 at the Portsmouth General Hospital. Two films were shown so that members could review them before they are shown before lay audiences. The films were "Time and Two Women," sponsored by the American Cancer Society; and "Hours to Live," sponsored by Hospital Care Association.

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

FRANKLIN

The Columbus Academy of Medicine Bulletin periodically publishes an "honor roll" of physicians who have donated blood to the American Red Cross Blood program. A recent roll lists more than 90 physicians, 11 of whom are "Gallon Club members."

A joint meeting of the Columbus Academy of Medicine and the Central Ohio Academy of

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Robins

1. Thomas, J. W.: Ann. Allergy 16:128, 1958

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Pharmacy was held on June 5. The following subjects were discussed by the speakers indicated:

"Steroids in Medicine," Byron Riegel, Ph. D., director of chemical research for the G. D. Searle Company, Chicago.

"Research Developments in the Field of Skeletal Muscle Relaxants," Dr. James M. Shaffer, director, Division of Clinical Investigation, McNeil Laboratories, Philadelphia.

"Current Function and Activities of the American Medical Association's Council on Drugs," Dr. H. D. Kautz, secretary, AMA Council on Drugs.

"Self-Medication and Our Professional Responsibilities," Linwood F. Tice, D. Sc., professor and associate dean of pharmacy, Philadelphia College of Pharmacy and Science.

The dinner meeting was held at the Neil House in Columbus.

New Members of OSMA

The following are the names of the new members of the Ohio State Medical Association since May 1st, 1958. The list shows the county in which they are affiliated, city in which they are practicing or temporary address in cases where physicians are taking postgraduate work.

Cuyahoga County
Julijonas Abraitis, Cleveland
Howard D. Arbuckle, Cleveland
Peter J. Brdar, Cleveland
Maria A. Crea, Cleveland
Alexander A. Klos, Cleveland
Mary Ellen McCarthy, Cleveland
Ivan H. Past, Cleveland
Victor Puskorius, Cleveland
Frederick A. Smith, Cleveland

Hamilton County
Celina D. Bobowski, Cincinnati
Erna L. Borousch, Cincinnati
Walter Schnur, Cincinnati

Lorain County
Robert S. Van Dervort, Elyria

Lucas County
Henrikas Solys, Toledo

Miami County
John D. Royer, Christiansburg

Ottawa County
Edward W. Kieffer, Elmore

Seneca County
Oswald G. Burkart, Tiffin

Stark County
Sylvester T. Centrone, Massillon
Yu-Ying Tsing Huang, Canton
Wayne L. McFadden, East Canton
Rudolf J. Nowara, Canton
Donald H. Volzer, Jr., Canton

Summit County
Richard H. Gollings, Barberton
E. Gates Morgan, Akron
Wilson D. Rees, Akron

Washington County
David D. Turner, Marietta

Greenfield—Dr. J. Martin Byers, Highland County coroner, was elected to the board of directors of the Ohio State Coroners Association at the group's annual meeting.

Van Wert—Dr. and Mrs. S. A. Edwards recently observed their 50th wedding anniversary. Dr. Edwards is a recipient of the OSMA 50-Year Pin.

Springfield—New president of the Ohio Valley Proctological Society is Dr. Ray M. Turner, of Springfield.

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Activities of Woman's Auxiliary . . .

CHAIRMAN PUBLICITY COMMITTEE—Mrs. W. J. Horger,
1100 Ohio Ave., East Liverpool, Ohio
(See Page 857 for roster of officers.)

CUYAHOGA COUNTY

The Woman's auxiliary of Cuyahoga County met May 21 for its annual meeting at the Academy of Medicine office. A box luncheon was enjoyed.

Mrs. Roscoe J. Kennedy, the outgoing president turned the gavel over to Mrs. Fred R. Rittinger.

Dr. Samuel Gerber, county Coroner talked on "Crime Detection" and then took the group through the county morgue.

Mrs. William A. Nosik, skit chairman, reported on the play "Panacea for Petticoats" the auxiliary members gave at the Academy annual meeting May 16. Mrs. Myron M. Perlick wrote the play. Other chairmen were: Mrs. Rupert Turnbull, Mrs. William Kutler, Mrs. Eduard Eichner, Mrs. Ben Abrams, Mrs. Nathan Krupkin, and Mrs. Roscoe J. Kennedy.

ERIE COUNTY

Next year's officers for the Woman's Auxiliary to the Erie County Medical Society are Mrs. P. S. LaFollette, president; Mrs. C. F. Lavender, president-elect; Mrs. D. V. Auld, vice-president; Mrs. R. E. Taylor, secretary and Mrs. Malcolm Boylan, treasurer.

They were installed during the auxiliary's May meeting at the home of Mrs. H. E. Snedden.

Mrs. W. P. Skirball conducted the business session which concluded her year in the presidency.

Reports on the recent Ohio State Medical Auxiliary convention in Cincinnati were given by Mrs. LaFollette and Mrs. Lavender. Their good tidings included the news that together with other local auxiliaries, the Erie County Auxiliary received a certificate showing it is a component unit of the Woman's Auxiliary to the Ohio State Medical Association.

Harry Mansfield, executive secretary of the Sandusky YMCA was the speaker of the afternoon. He discussed the origin of the "Y" and explained the meaning of its emblem.

Tea was served at a table appointed with spring blossoms and pink candles. Mrs. LaFollette and Mrs. Lavender presided. Mrs. C. R. Swanbeck, Mrs. R. D. Fishell and Mrs. E. J. Baxter assisted Mrs. Sneddon on the hostess committee for the day.

FAIRFIELD COUNTY

The Woman's Auxiliary to the Fairfield County Medical Society was invited to the home of Mrs. F. W. James for its May meeting. Assisting Mrs. James were, Mrs. C. B. Snider, Mrs. James Beesley, Mrs. K. W. Taylor, Mrs. A. B. Van Gundy.

Lunch was served to 22 members and two guests, Mrs. Hector McKnow, president of the Woman's Auxiliary to the Licking County Medical Society and Mrs. J. R. Wells, Newark, director of the Eighth District of the Woman's Auxiliary to the Ohio State Medical Society.

Mrs. George LeSar presided for the business meeting. A report of the Ohio State Medical Auxiliary Convention was presented by Mrs. G. F. Jones.

The following officers for the Fairfield County Medical Auxiliary were installed by Mrs. Wells: President, Mrs. G. F. Jones; Vice President, Mrs. James Beesley; President-Elect, Mrs. C. F. Clark; Secretary, Mrs. W. D. Nusbaum; Treasurer, Mrs. C. H. Hamilton.

Mrs. LeSar presented Mrs. Jones with the gavel and the new president announced the appointments of committee chairmen.

In addition to the various other projects sponsored by the Medical Auxiliary, the group is currently concerned with providing recreational equipment for the student nurses of the Lancaster-Fairfield Hospital School of Nursing.

HAMILTON COUNTY

A buffet supper followed by informal and square dancing replaced the usual May meeting of the Woman's Auxiliary to the Hamilton County Medical Society. A country atmosphere accented with scarecrows prevailed at the Hartwell Country Club on the evening of May 20. Straw hats and sunbonnets were provided as table favors, and became the appropriate headdress for the party.

Mrs. Earl C. Van Horn was installed as president for 1958-59 in a brief business interlude. Others taking office were Mrs. Don Berning, president-elect; Mrs. William C. Ahlering, vice-president; Mrs. Edward O. Hoffman, recording secretary; Mrs. George Ballou, corresponding secretary; and Mrs. Charles Hoyt, treasurer.

Thirty-nine members were entertained at an informal gathering on May 7 at the home of Mrs. Van Horn. Officers and members of the executive board also attended the party, for which the new members planned the entertainment. It was the third and final orientation meeting of the year.

KNOX COUNTY

The Woman's Auxiliary to the Knox County Medical Society held its annual luncheon in the Alcove on May 28.

Following the lunch, Mrs. C. H. Bell of Mans-

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field, the new state auxiliary president, was introduced. She addressed the group on the auxiliary work in National, State, and County levels. She stressed the importance of the work done by small groups.

The new officers installed were: President, Mrs. George Imhoff; president-elect, Mrs. A. S. Mack; vice president, Mrs. Charles Tramont; secretary-treasurer, Mrs. O. W. Rapp.

Mrs. James F. Lee, Mrs. Charles Tramont, and Mrs. Howard Dillon were hostesses.

MAHONING COUNTY

Funds were raised for two nursing scholarships, one for St. Elizabeth and one for Youngstown Hospital, and $350 was contributed to the American Medical Education Foundation, reports revealed at the annual meeting of the Woman's Auxiliary to the Mahoning County Medical Association on May 7 at Youngstown Country Club.

Mrs. Cary S. Peabody, president, presented the review of the past year's accomplishments. Mrs. Robert L. Tornello was chairman of the scholarship committee. The paid-up membership now totals 229. Mrs. Paul J. Mahar gave a report of the state convention held in Cincinnati, at which the local auxiliary received an award for selling the most subscriptions to *Today's Health,* the official magazine of the American Medical Society. Mrs. Lester Gregg was chairman for that project.

New officers, headed by Mrs. Earl H. Young as president, were installed by Mrs. Ivan C. Smith, a past president. Mrs. C. E. Prichette, vice president, Mrs. James A. Patrick, corresponding secretary, Mrs. E. M. Thomas treasurer, Mrs. Edward G. Rizk recording secretary, and Mrs. A. E. Rappoport president-elect. In appreciation of her service, Mrs. Peabody was presented a gavel, a gift from the auxiliary, by Mrs. Mahar.

Dinner appointments were beautiful. Mrs. Mahar offered the invocation, and Mrs. R. M. Morrison read the auxiliary pledge.

Featured on the program was the humorous skit, "Doctor, This Is Your Wife," a take-off on auxiliary committee work, directed by Mrs. Frank Inui, program chairman for the evening.

Mrs. Inui's co-chairmen were Mrs. B. I. Firestone and Mrs. Alfred Cukerbaum. Mrs. Fred Schlecht was social chairman, with Mrs. Stillson, Mrs. Ben Brown and Mrs. Harry Smith as her co-chairmen.

SCIOTO COUNTY

Spring flowers decorated the home of Mrs. H. M. Keil for the annual May breakfast of the Woman's Auxiliary of Scioto County Medical Society. Each member was presented with favors of miniature china roses.

Installation of officers by Mrs. Clyde M. Fitch, a past-president of the auxiliary, followed the breakfast.

The new officers are President, Mrs. Armin Melior, President-Elect, Mrs. A. L. Berndt, Vice-President, Mrs. William Singleton, Secretary, Mrs. L. B. Hatch, Treasurer, Mrs. G. E. Neff, Historian, Mrs. Milton Levine, and Mrs. George W. Martin, advisory board.

Mrs. Samuel L. Meltzer, past state vice-president and new state chairman of credits and awards, reported on amendments voted by the Woman's Auxiliary of the Ohio State Medical Association at the convention in Cincinnati.

Mrs. Hugenberg, the retiring president, also reported on the state convention.

SUMMIT COUNTY

The Woman's Auxiliary to the Summit County Medical Society met for a brunch on May 6 at the Akron City Club.

Members were pleased to have Mrs. V. R. Frederick, 1957-1958 President of the Woman's Auxiliary to the Ohio State Medical Association to install the following officers for 1958-1959: President, Mrs. Devitt L. Gordon; president-elect, Mrs. Robert J. Hemphill; vice-president, Mrs. Carl T. Korsmo; treasurer, Mrs. Robert S. McMillen; recording secretary, Mrs. A. H. Loomis; corresponding secretary, Mrs. B. F. Suffron.

Delegates to the State Convention were Mrs. Philip B. DeMaine, Mrs. Joseph J. Eckert, Mrs. H. E. Muller and alternate Mrs. Donald I. Minnig.

The program was a skit starring several members of the Auxiliary entitled "Doctor, This is Your Wife." Mrs. A. H. Kyriakides was chairman.

Ohio Physicians Participate in Obstetricians' Program

Several Ohioans participated in the recent sixth annual clinical meeting of the American College of Obstetricians and Gynecologists held in Los Angeles.

Dr. Richard D. Bryant, Cincinnati, was chairman of the Scientific Exhibit Committee.

Dr. John C. Ullery and Dr. John H. Holzaepfel, Ohio State University, received honorable mention for their exhibit, "Radioactive Isotopes in Gynecologic Malignancies."

Drs. Howard P. Taylor, William A. Hawk and John J. Cahill, Cleveland, received honorable mention for their exhibit, "Placenta Accreta, Increta and Percreta." This exhibit was displayed at the OSMA Annual Meeting in Cincinnati also.

Dr. Ullery is current secretary of the organization.

Voluntary Health Agencies . . .

The Columbus Academy of Medicine Completes Its Survey of Health Organizations; Recommends Combined Single Fund-Raising Campaign

A COMPLETE survey of the activities of 38 voluntary health agencies in Columbus and Franklin County has led the Columbus Academy of Medicine to recommend that all fund-raising health agencies combine into a single united fund campaign.

The survey began in 1957 with the appointment of a Fund-Raising Health Agencies Screening Committee, a sub-committee of the Academy's Medical Service Committee.

The committee's assignment was to conduct a fact-finding survey of the voluntary health agencies.

Asked 78 Questions

The committee devised a questionnaire for the survey. It consisted of 78 questions concerning organization and function. The 38 agencies then were personally surveyed by members of the committee. Findings of the committee included information that total funds administered by the 38 agencies amounted to $6,573,132, with $3,087,184 being expended for health and the remaining $3,485,948 for welfare activities of those health agencies.

The questionnaire covered the individual agency's affiliations with national, state or central Ohio agencies, including a list of counties where applicable, purpose and objectives.

Data Developed

It developed data on organization, method of elections, medical advisory board, paid personnel, volunteer groups and special committees. It also determined if the agency's local campaign was federated or separate. If the latter applied, the relationship to national campaigns was studied.

Financial information obtained included total budget, sources, allocations to local, state and national organizations and the use of those allocations, monies returned to Columbus as research grants, local salaries and other fixed costs.

Activities, education, care programs and services were covered in detail, along with anticipated budget and program increases.

The committee determined the need for each particular health agency in the community by studying the incidence of the disease and the local scope of the problem. These data included total cases listed by each agency in Franklin County, incidence in the general population, anticipated new cases per year, importance of the disease as a cause of death, and anticipated old cases requiring care per year.

Academy Report

In its report to the Academy, the committee stated, "The question was asked as to whether or not local services and facilities, other than those of the local chapter, could provide such services. The need for research was discussed and local expenditures for research during last fiscal year were listed, including the recipient, progress reports and publications. The need for free medication and treatment was estimated when possible. Finally, recommendations were made to be presented

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to the Academy members of the (United Appeals) Screening Committee."

Of the 38 agencies surveyed, 19 were United Appeals participants and 19 were not.

Advocates Screening Committee

As a result of the survey, the Columbus Academy proposed a central screening committee, consisting largely but not entirely of physicians, which would consider all disease and health needs of the community in setting campaign goals and allocating funds.

Other results of the committee's activities:

An offer to each agency to provide a list of physicians interested in specific disease entities and willing to serve on medical advisory councils.

An invitation to each agency to prepare a short summary of its organization, objectives, including services useful to physicians in their practice, for publication in the *Academy Bulletin.*

Continuation of the subcommittee as a permanent unit, with appointment on a three-year rotating basis.

Research Funds Available

Recommendation that interested physicians in Franklin County apply for research grants from national health agencies since "far more funds are leaving our community than returning to it."

Strong recommendation that considerable thought be given to the possibility of a unified voluntary health drive to obtain funds for all voluntary health agencies.

"Finally, the Committee is unanimously in favor of continuing growth and physician support of the voluntary health agencies, having been firmly convinced that contributions to these activities are far better than the dead hand of government taxation."

The report and recommendations drew the endorsement of the Columbus United Appeals board of trustees.

Interprofessional Committee Formed in Clark County

Clark County Medical Society has been instrumental in organization of an Interprofessional Medical Committee, which includes, in addition to the medical profession, representatives of nursing, pharmaceutical, dental and veterinary organizations.

The committee was formed to sponsor medical exhibits at the Clark County Fair, sponsor public health projects, prepare monthly news items for public interest, provide speakers for youth groups, have a standby disaster committee, correlate public information related to the different professional fields, bring together mutual problems, and to bring the professional groups closer together.

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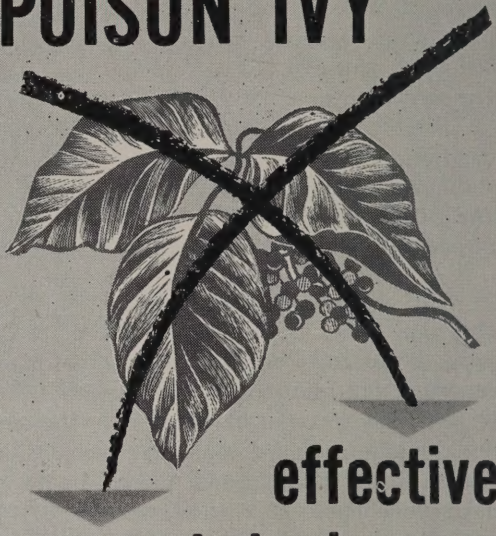


Hospital Questions . . .

Queries Are Answered by Joint Commission on Accreditation in Regard To Various Matters and Policies Dealing With Hospital Administration

THIS is another article presenting questions which have been asked of the Joint Commission on Accreditation of Hospitals and the Commission's answers:

May a hospital staff grant privileges to a chiropodist? What is his status? What are his privileges?

A hospital staff may vote a chiropodist privileges in his specialty. Each hospital staff must evaluate the chiropodist who applies for hospital privileges and set up qualifications, rules and regulations. Granting privileges to a qualified chiropodist will not cause the hospital to be penalized by the Joint Commission.

Chiropodists must be under the jurisdiction of the department of surgery. A physician must be in attendance when the chiropodist is performing in the hospital on an inpatient. Where minor outpatient podiatry is performed, it will be done under the supervision of the surgical department though actual attendance is not required. The chiropodist is in the nature of a technician, functioning under the surveillance and supervision of a physician.

Limitations Noted

The chiropodist is not qualified to write the history or physical examination nor check the heart and lungs before an anesthetic. This applies also to prescribing drugs both pre-operatively and post-operatively in the hospital. These functions can only be performed by a physician on the staff or having privileges in the hospital in question. The podiatric patient must be admitted to the hospital under the physician's name. The chiropodist cannot and does not have the privilege of admitting a patient under his own name.

It is in no way obligatory that a chiropodist be given privileges. It is up to each individual hospital staff to evaluate the hospital's needs, the individual's qualifications and competence, and then vote on the matter with recommendations to its board of trustees. The board of trustees of any hospital, before giving approval to such election, should make sure that the hospital's by-laws, rules and regulations spell out all facts and privileges.

Is it necessary to have consultation on every "D and C"?

No. The standards state specifically that a consultation is necessary only when a pregnancy is definitely present or suspected. If pregnancy is suspected, a pregnancy test would be very wise as a precautionary measure.

No consultation is necessary if the physician has definitely seen products of conception passed (incomplete abortion). It likewise is unnecessary when there is no question of pregnancy, but the physician desires to do a diagnostic "D and C" to determine if some other pathology, such as possible endometriosis or cancer, is present.

Mass Casualties

We have been told by the Joint Commission on Accreditation of Hospitals that besides a fire plan and drills, we must have a plan and drills for the reception and handling of mass casualties and for the evacuation of patients. How do we do it? Is this the same as civil defense or disaster planning?

No, this is not civil defense, but a good plan for reception of mass casualties and evacuation of patients is a main facet of a civil defense hospital program and could easily be coordinated into and with it. The JCAH requirement is that you have a planned and rehearsed program to take care of a major catastrophy within your own hospital, or within your own community if it occurs.

Each hospital must have its own individual plans. Every effort should be made to coordinate the hospital's plan with those of other hospitals and other community agencies and organizations.

I. **Drills or rehearsals of these plans should be held at least twice a year.** Care should be exercised so that all shifts know the plans and take part in them.

II. **Every hospital must have a written plan.** It should embody the following basic components:

A. Evacuation.
  1. Internal (to other parts of the hospital).
  2. External (to homes, other hospitals or designated areas).

B. Reception and expansion.
  1. Internal (usage of hospital personnel and facilities).
  2. External (usage of above plus available outside facilities).

C. Continuation of services provide for alternative sources of vital utilities and supplies of foodstuffs, fuel, medical-surgical and pharmaceutical items.

D. Coordination and integration.
  1. With plans of other hospitals.
  2. With plans of community agencies and organizations (police, fire department, health department, Red Cross and Civil Defense).

Categories I and II should be broken down into explanations of the functions and duties of personnel and of usage of facilities and equipment. General considerations for this programing are:

1. Authority.
   a) Lines of authority must be established.
   b) Organizational chart.
2. Personnel.
   a) Lists of key personnel—notification procedures.
   b) Duty assignments.
3. Communications.
   a) Notification.
   b) Duties.
   c) Usage of communications.
   d) Communication center.
4. Traffic control.
   a) Plans for both internal and external control.
   b) Traffic flow charts.
5. Utilities.
   a) Prior arrangements in case of loss.
   b) Alternate sources.
6. Records and identification.
7. Supplies and equipment.
   a) Usage of available equipment and supplies.
   b) Sources of supplies.
8. Public information center.

Every hospital department and service should know its duties and functions. These include: administration, medical staff, nursing staff, pharmacy, central supply, medical records, dietary, engineering and maintenance, personnel, supply, housekeeping, laundry, information and communication, and business and admitting.

The Department of Otolaryngology, University of Illinois College of Medicine, announces its Annual Assembly in Otolaryngology from September 29 through October 5, 1958. Interested physicians should write direct to the Department of Otolaryngology, 1853 West Polk Street, Chicago 12, Illinois.

Hospital Agreement Violates Fee Splitting Principle Judicial Council Says

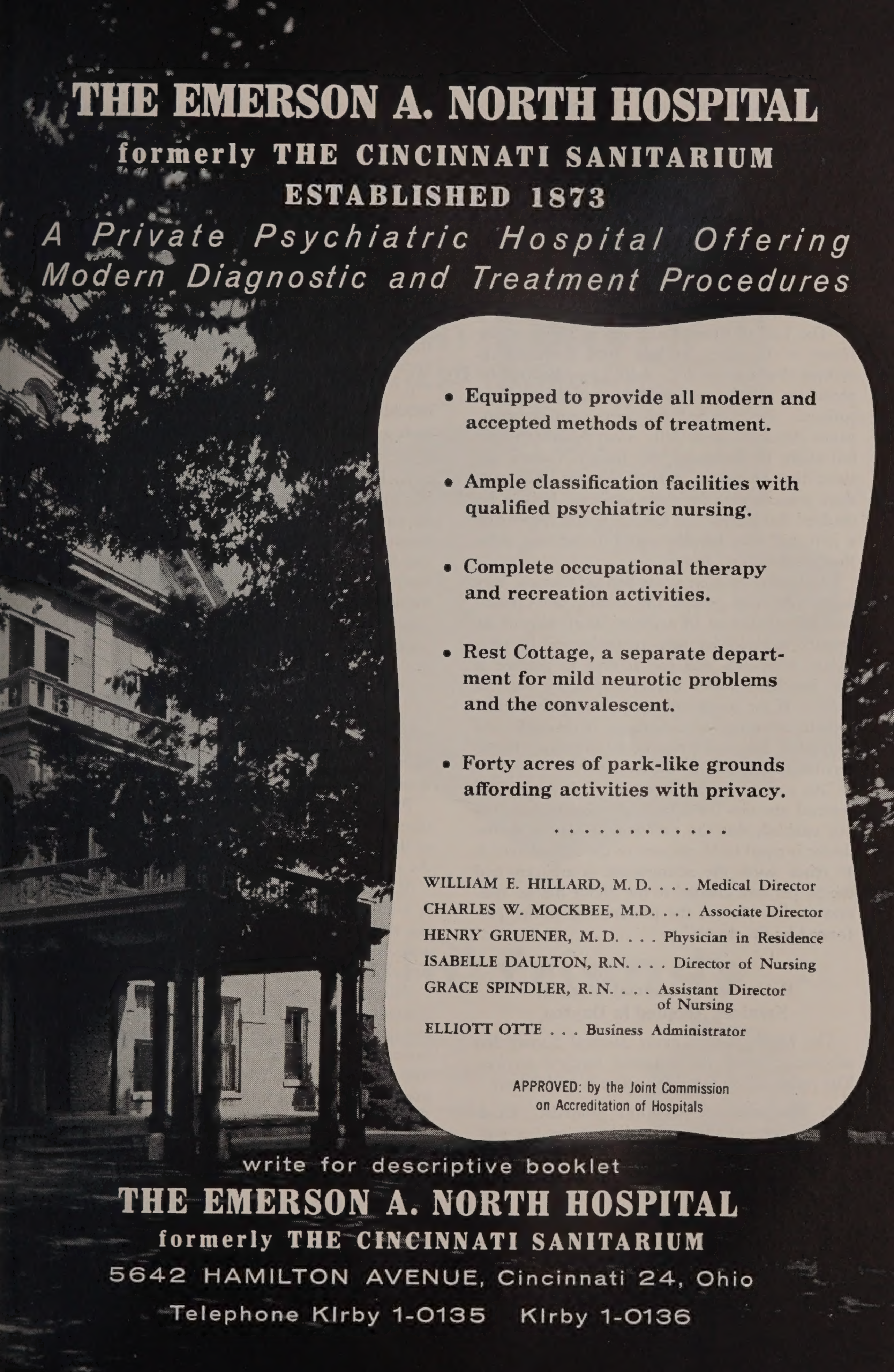
An opinion on fee splitting was rendered by the Judicial Council of the AMA to a member of the American College of Surgeons at the request of the Chairman of the Board of Regents of the ACS. It was in the form of a letter from the Executive Secretary of the Council, reading as follows:

"Dr. Ravdin, chairman of the Board of Regents of the American College of Surgeons, has referred certain correspondence of yours which refers to an agreement between physicians and a hospital . . . to the Association for consideration and reply.

"From this correspondence it appears that the hospital in question has proposed that collections from all outpatient x-rays are to be divided equally between the member of the medical staff who ordered the x-ray and the hospital; and that collections from all inpatient x-rays are to be retained by the hospital with the exception of radio-opaque studies of soft tissues which will be divided equally between the hospital and physician. This agreement recognizes that pathology and radiology are medical services and provides that itemized statements will show the name of the doctor rendering the service and the charges by the doctor and the hospital . . . In the absence of a competent radiologist in the area, each doctor interprets his own x-rays.

"The Judicial Council has stated that a physician himself should submit a bill for the professional service he renders to the patient. (It has not said that this bill may not be submitted by another for him on his behalf.) The Judicial Council has for many years expressed disfavor with the practice of sending a combined bill. Consequently the fact that the hospital sends an itemized bill showing the charge of both hospital and physician would seem to be contrary to interpretation of Chapter I, Section 6 of the *Principles of Medical Ethics* by the Judicial Council. (The reference is to the 1955 edition of the *Principles of Medical Ethics,* which were revised by action of the A. M. A. House of Delegates in June, 1957. However, the Judicial Council has stated that no opinion or report of the Council interpreting these basic principles which were in effect at the time of the revision has been rescinded by the adoption of the 1957 version.) The contract offered by the hospital merely provides a procedure whereby the bill for two distinct services is sent patient.

"The Association has never recognized that radiology or pathology is divisible into professional and nonprofessional aspects. Pathology and radiology



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are the practice of medicine. They are to be practiced only by those qualified and licensed to perform them. Fees for that professional service are to be set, billed and collected by the doctor who actually performed the service. No provision is made in the contract providing who shall set the fee for the 'service.' It merely provides how the fee is to be divided and may put the physician in the position of having to set his fee for a professional service according to the wishes or dictates of the governing board of the hospital.

"The Judicial Council in a special report to the House of Delegates in June 1954 reiterated its opinion that separate bills should be submitted by physicians for the services they rendered to their patients. It recognized that some insurance companies demand a single bill. Even though a single bill might be demanded, the Judicial Council insisted that physicians should, however, seek separate remuneration for their services. It is to be doubted that the Judicial Council would approve of a joint bill of a hospital and a doctor, any more than joint bills of doctors.

"In another opinion of the Judicial Council, having to do with groups and clinics, the Council pointed out that an arbitrary 50-50 division of an amount received for services performed by physicians associated with one another in practice is not justifiable under the *Principles of Medical Ethics*. If for bookkeeping purposes a division of income according to percentage is desirable and warranted, such ratio must be in proportion to the services contributed by each doctor.

"An analogy seemingly would apply here. The contract provides for a 50-50 distribution but does not establish that the professional service of the doctor is equal to 50 per cent of the bill submitted. In other words the arrangement is arbitrary and the 50 per cent allotted to the doctor has no relation to the value of the professional service performed by the doctor."

Policy on Industrial Medical Services Adopted in Dayton

The Montgomery County Medical Society has adopted a policy on industrial medical services. The policy which is now in effect is as follows:

1. The policy set down in a pamphlet, "Guiding Principles of Occupational Medicine," as published by the Council on Industrial Health of the A. M. A. in 1954 and a similar brochure, "The Scope of Industrial Medicine," published in 1957 is accepted.

2. "An industrial physician shall not, while caring for an industrial injury or disease urge a patient to have an unrelated concomitant and coincidental disease treated by himself at the worker's expense."

3. "When a case is diagnosed as non-occupational, the patient is referred to the physician of his choice."

4. "The treatment of injuries or diseases not occupationally induced is the function of private medical practice."

5. Radiological procedures in nonindustrial cases should cease entirely, except for pre-hiring chest films or when occupational disease is suspected.

6. Laboratory studies performed on employees, should be limited to those cases directly concerned with an occupational disease or injury, or when there is a question of continuing employment.

7. Private physicians shall refrain from requesting medical departments of industry to perform laboratory and x-ray studies on non-occupational diseases or injuries. If the employee himself requests the medical departments for laboratory or x-ray films, the industrial physician should refer the employee to the private physician of his choice.

8. Failure to conform with these policies will be considered a violation of medical ethics.

ACR Policy on Retention Of X-Ray Films

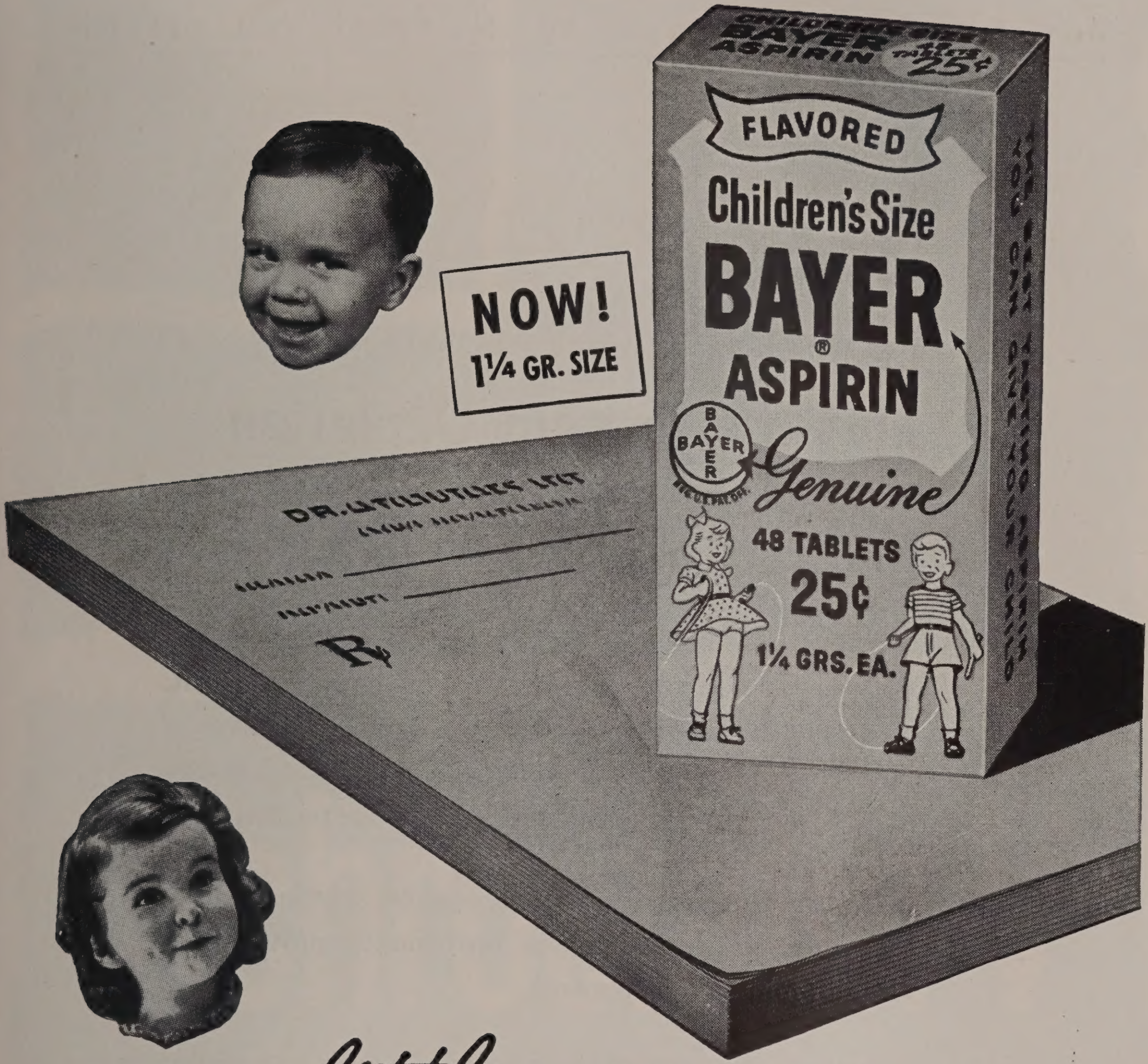
The American College of Radiology has adopted the following suggested policy regarding the retention of x-ray films:

Properly made medical roentgenograms of human beings are objective records of certain aspects of the status of the person, or persons, so examined. As such, they may constitute valuable records.

Valuable records should be stored as long as is locally practicable. This may be done by storing the original roentgenograms, or storing standard size or reduced size copies of same. Selected or key roentgenograms may be selected for copying.

When space, or other requirements, demand limitation of storage, it is recommended that in the average office or department roentgenograms be maintained for at least five years. It is desirable that apparently negative chest films of adults be maintained, if possible, for 10 years. In many offices and departments roentgenograms of teaching value, or of an unusual nature, are filed *sine die*. This is to be encouraged.

Before discarding roentgenograms, it is recommended that when practical the referring physician or, at his discretion, the patient be given the opportunity of obtaining them for filing in a safe place.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*Finnerty, F. A. Jr.: New York State J. Med. 57:2957 (Sept. 15) 1957.

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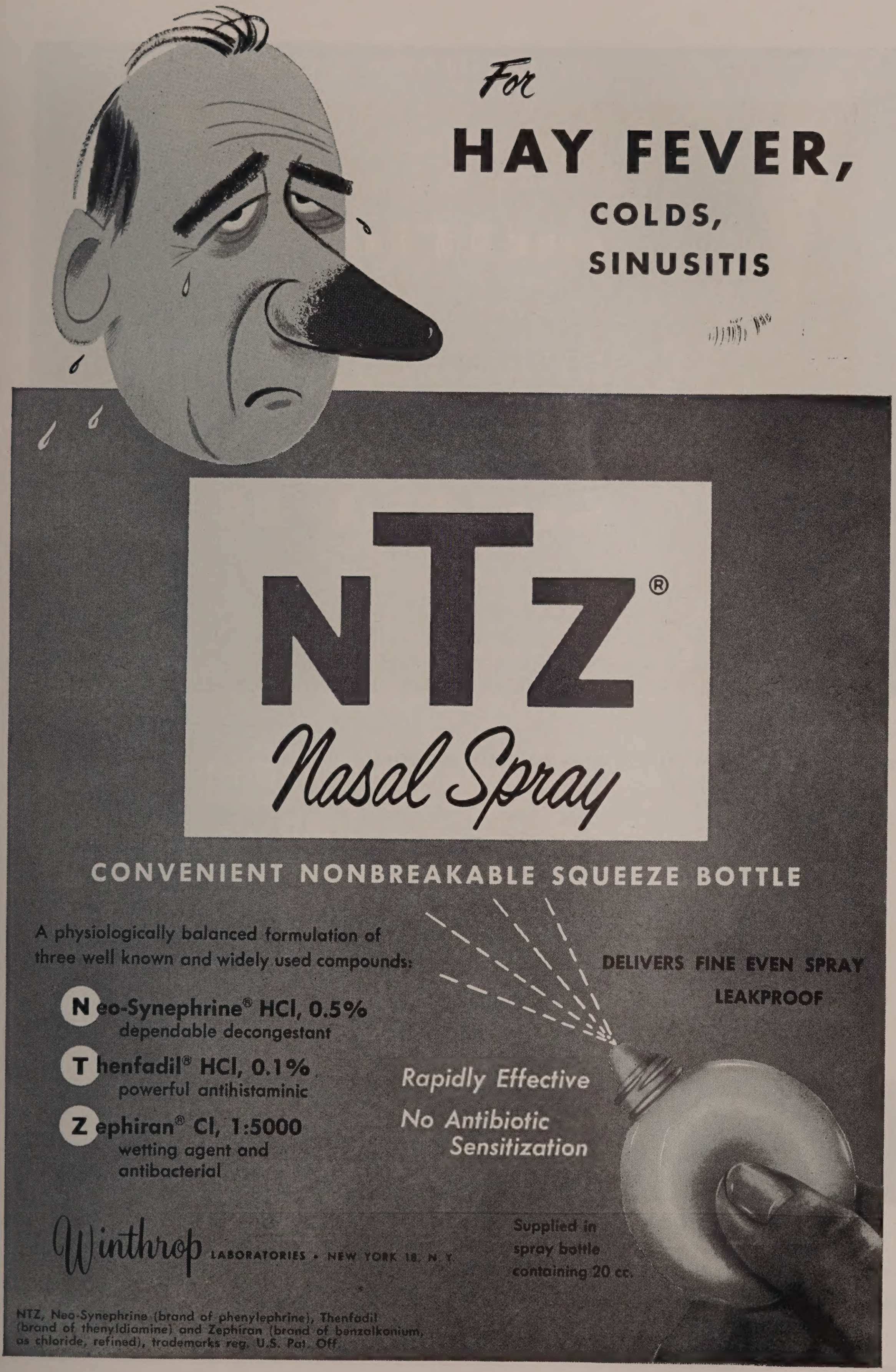

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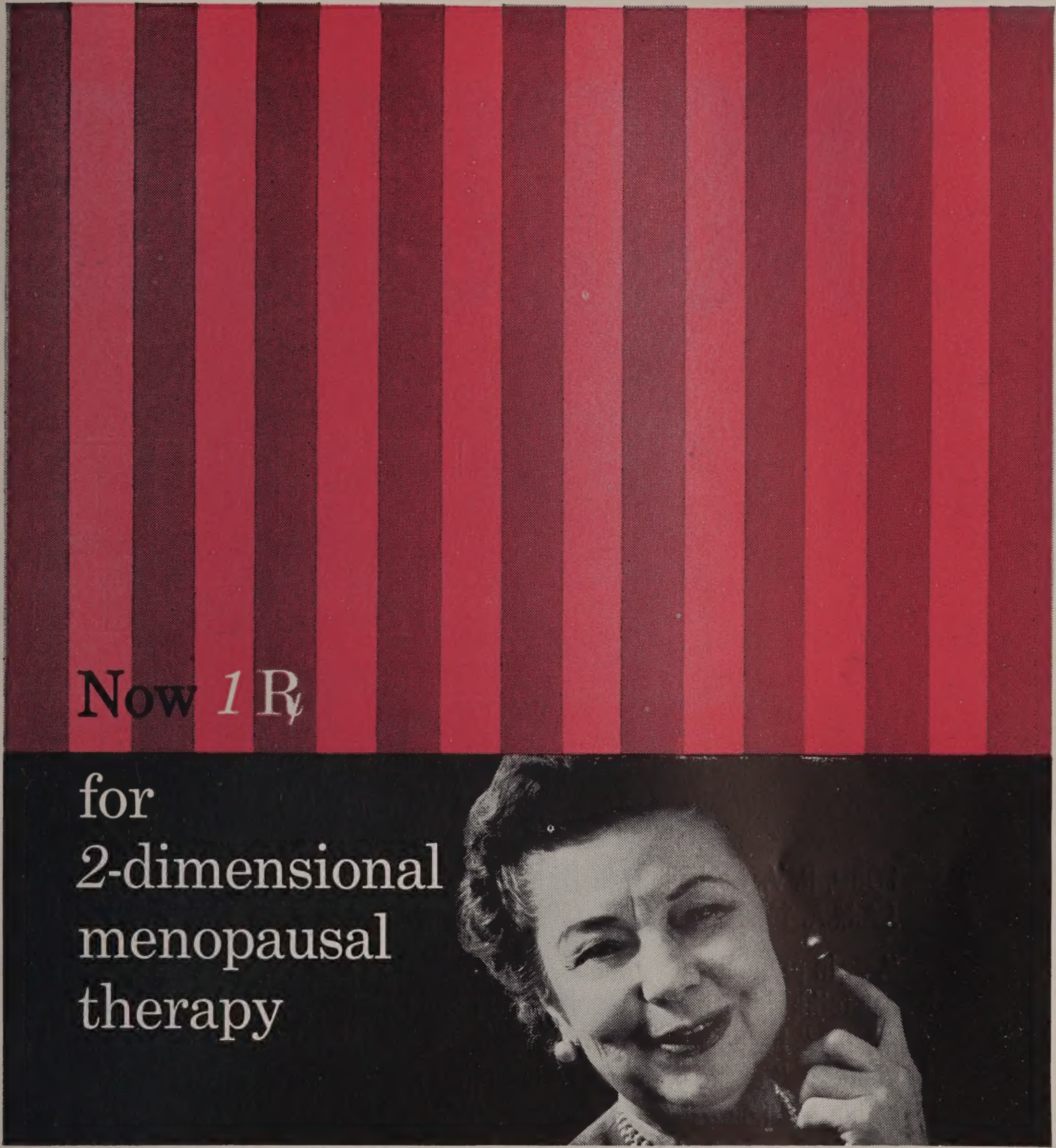

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FORD, R. V., Rochelle, J.B.III, Handley, C. A., Moyer, J. H. and Spurr, C. L.: J.A.M.A. **166**:129, Jan. 11, 1958.

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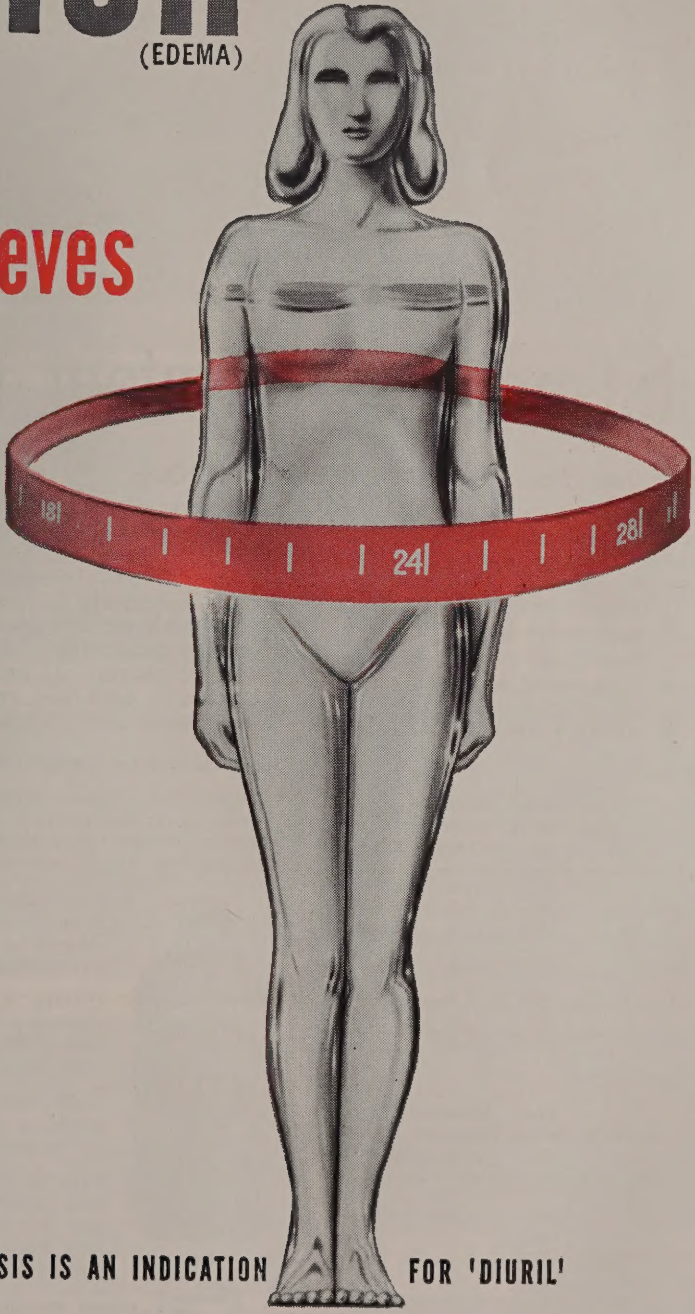

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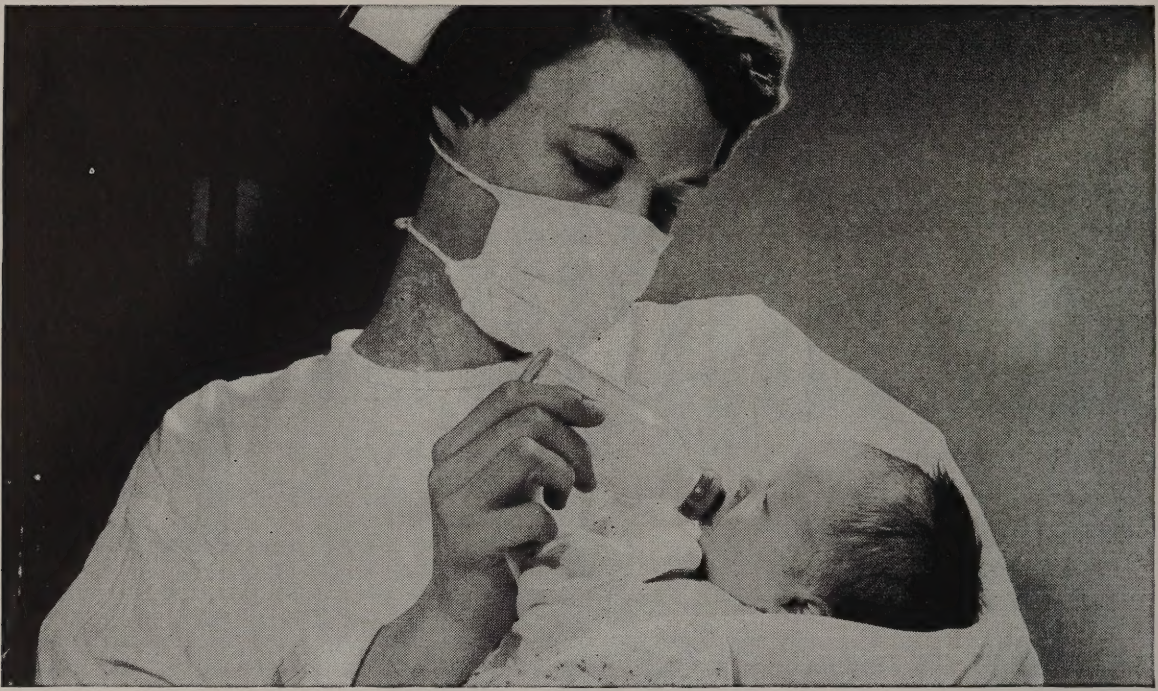

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Age Months	Whole Milk Fluid Oz.	Water Oz.	Karo Syrup Tbsp.	Each Feeding Oz.	Number of Feedings in 24 Hours	Total Calories
Birth	10	10	2	3	6	320
1	12	13	3	4	6	532
2	15	13	3	4½	6	480
3	17	9	3	5	5	520
4	20	11	3½	6	5	610
5	23	11	4	6½	5	700
6	26	10	4	7	5	760

EVAPORATED MILK FORMULAS

Age Months	Evaporated Milk Fluid Oz.	Water Oz.	Karo Syrup Tbsp.	Each Feeding Oz.	Number of Feedings in 24 Hours	Total Calories
Birth	6	12	2	3	6	380
1	8	16	3	4	6	532
2	9	14	3	4½	5	576
3	10	15	3½	5	5	650
4	12	18	4	6	5	768
5	12	21	4	6½	5	768
6	13	22	4	7	5	812

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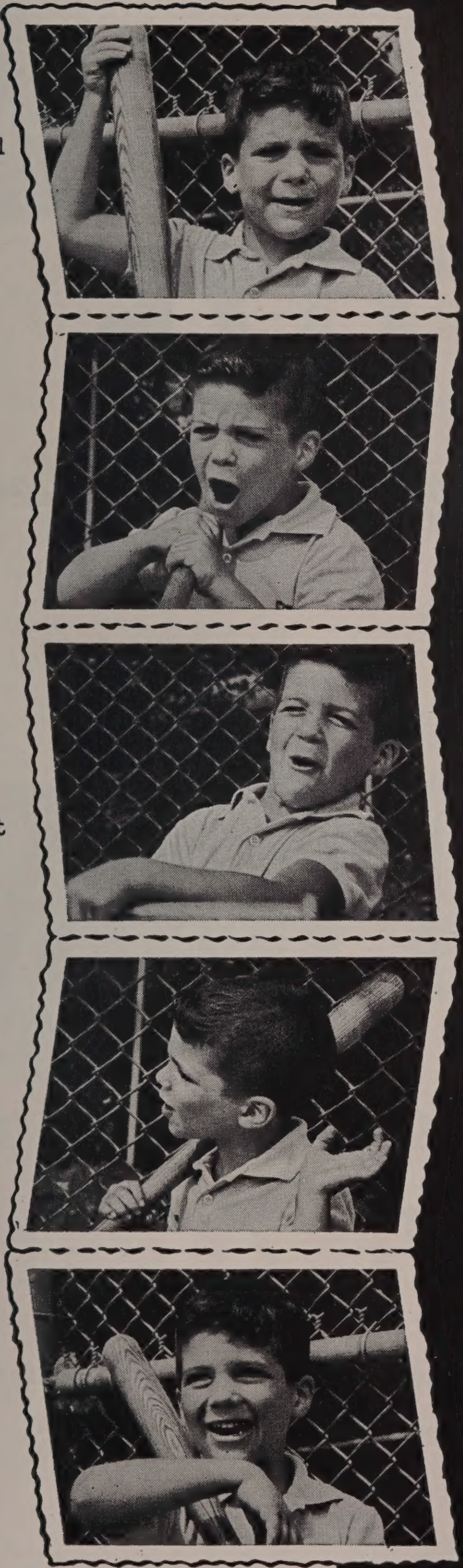

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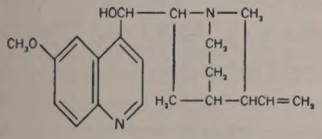

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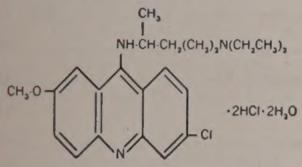

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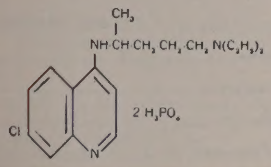

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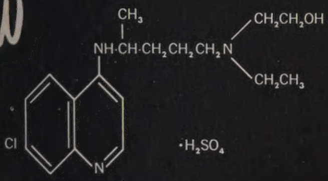

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cherbel, A.L., Schuchter, S.L., and Harrison, J.W.: *Cleveland Clin. Quart.* 24:98, Apr., 1957.
choch, A.G., and Alexander, L.J.: The Schoch section, *Bull. A. Mil. Dermatologists* 5:25, Nov., 1956.
ornblest, Theodore: Arch. Dermat. 73:572, June, 1956.

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Ohio State Medical Association, 1959 Annual Meeting, April 21-24, Columbus.

American Medical Association, Clinical Session, December 2-5, Minneapolis, Minn.

Ohio Academy of General Practice, Annual Scientific Assembly, October 1-2, Toledo.

University of Cincinnati College of Medicine, Postgraduate Course in Heart Disease, Cincinnati, September 3-6.

Sixth Councilor District, Postgraduate Day, October 22, Akron.

CORRECTION

In the tabulations on page 794, June issue of *The Journal,* an error was made in reporting the total membership of the Ohio State Medical Association as of December 31, 1957. The correct total membership as of that date was 9070.

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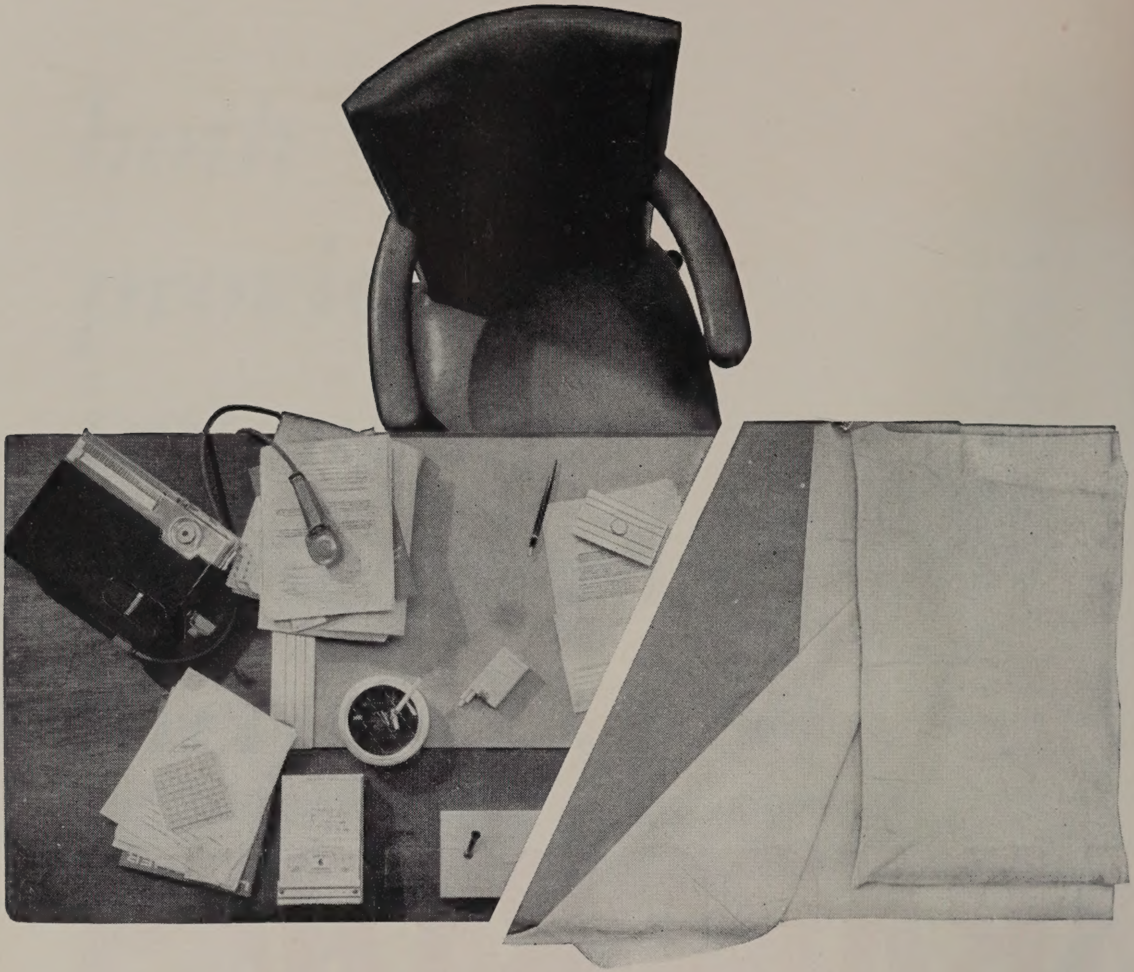

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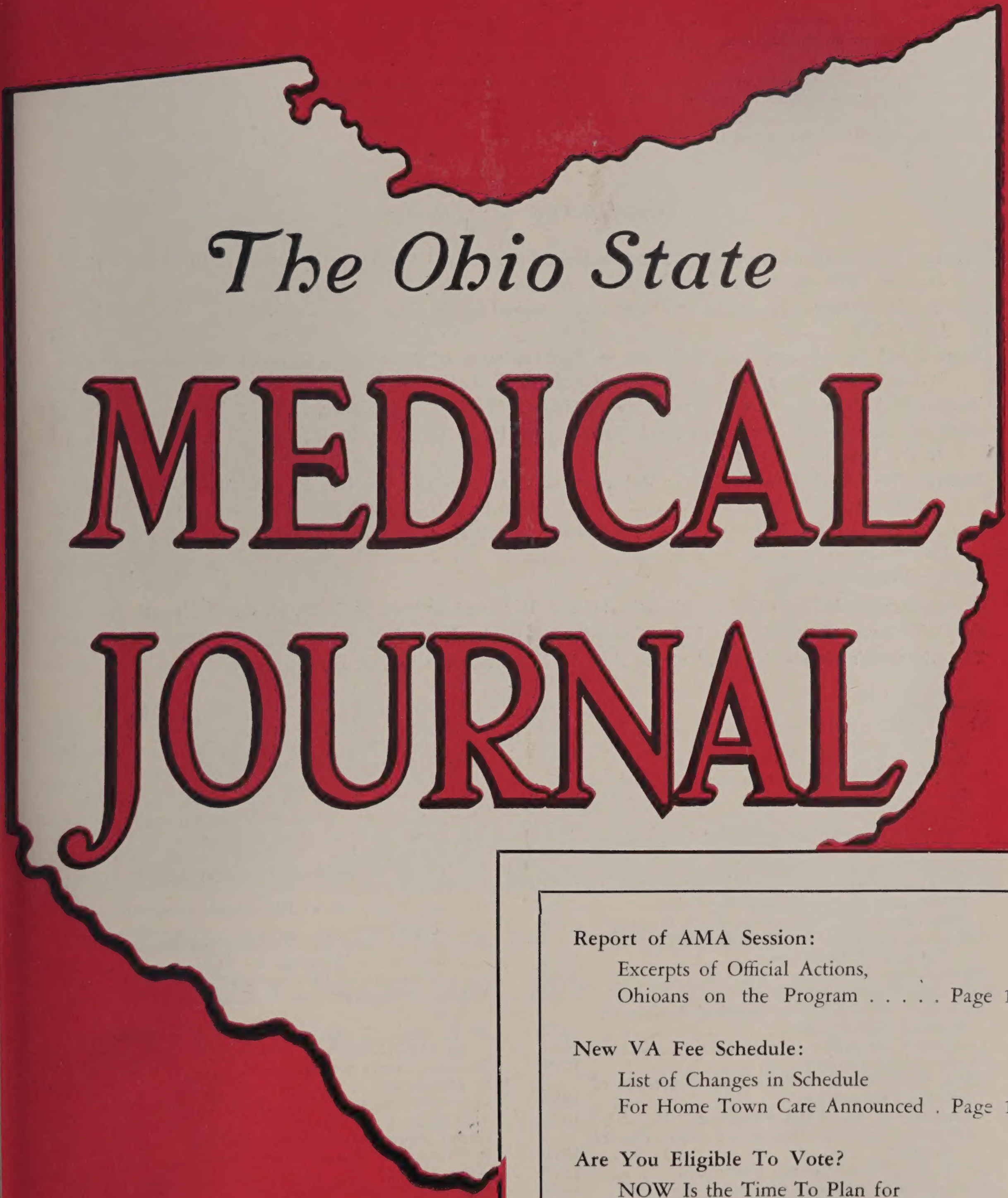

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The Ohio State Medical Journal

Vol. 54 August, 1958 No. 8

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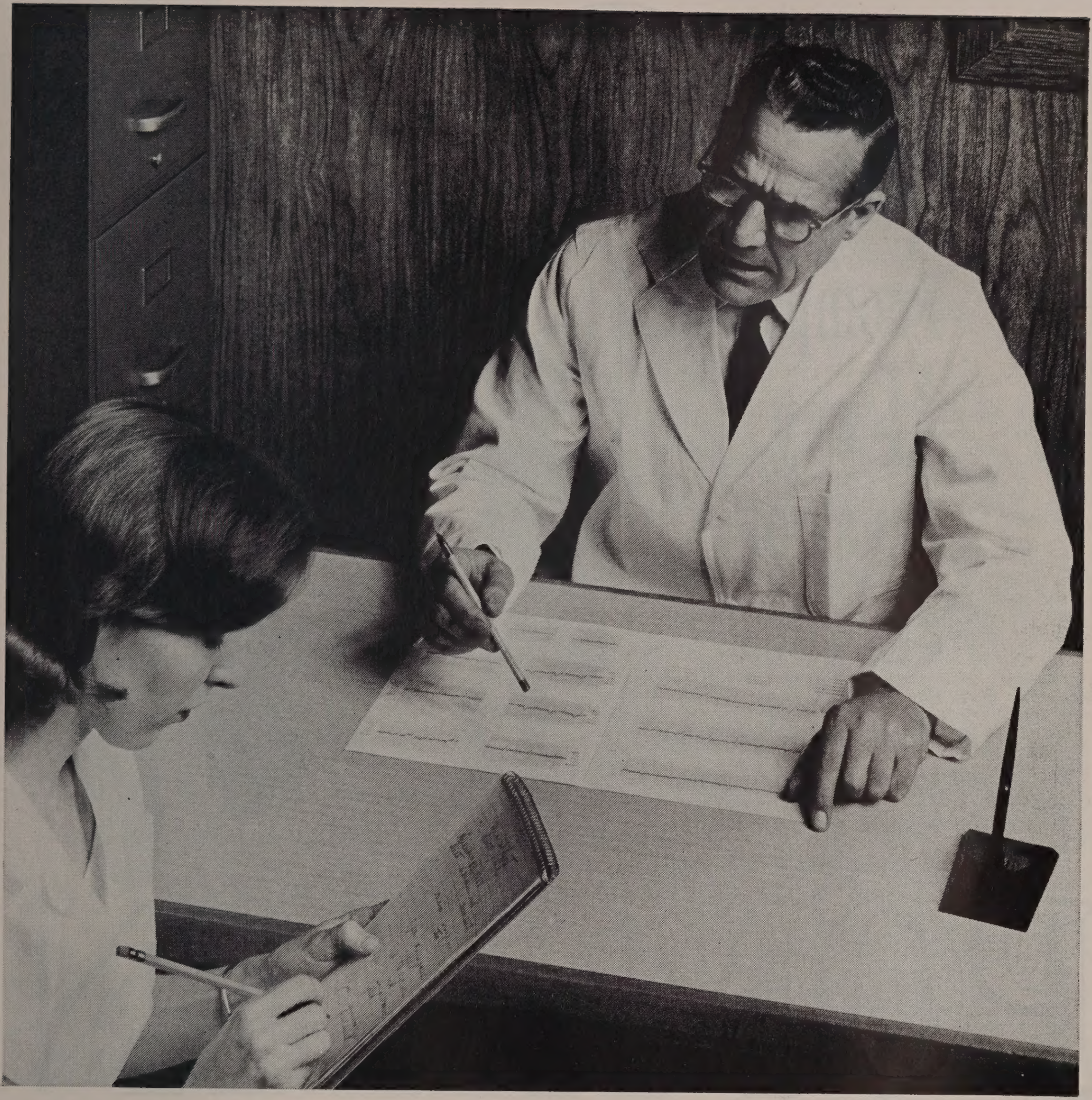

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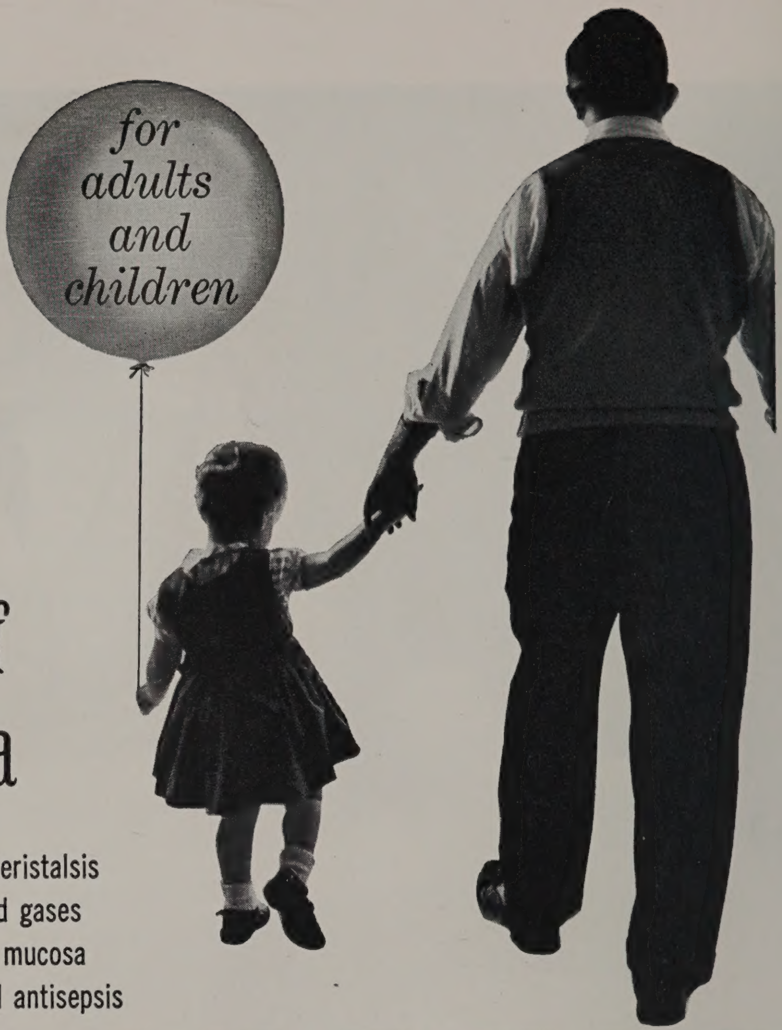

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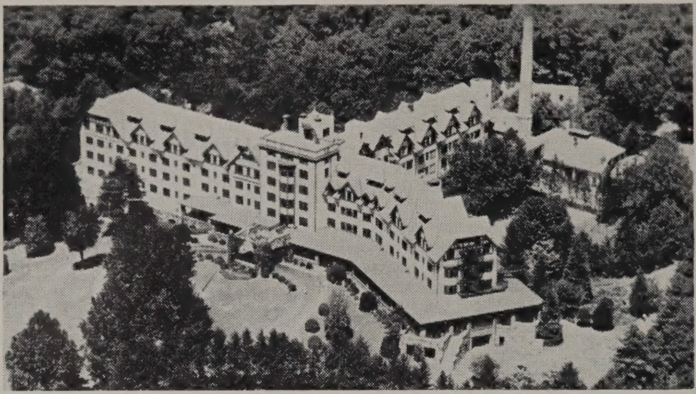

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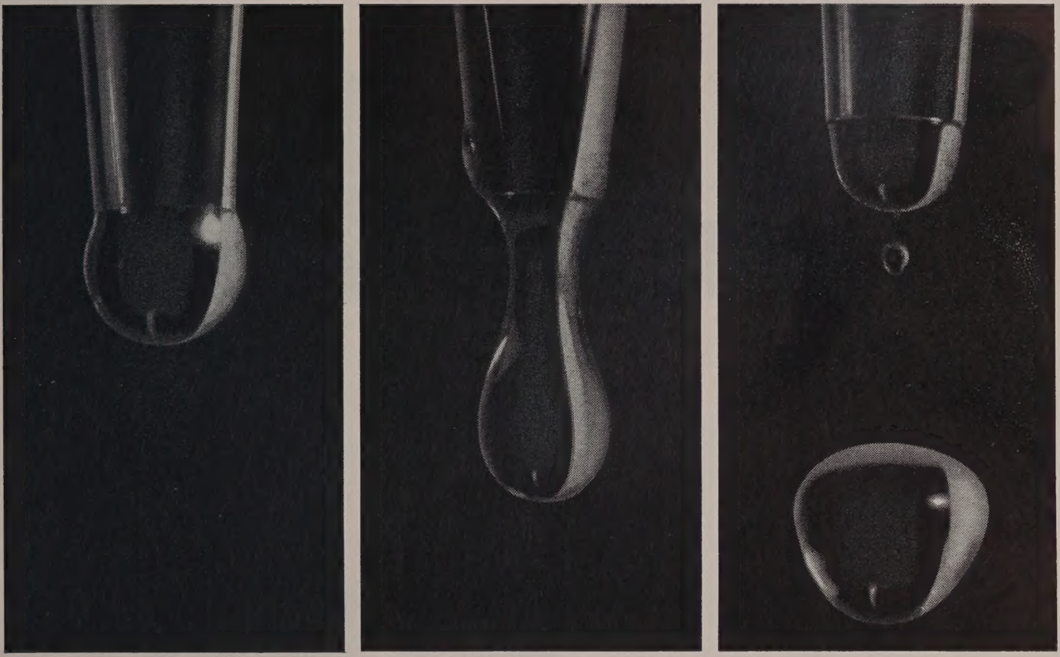

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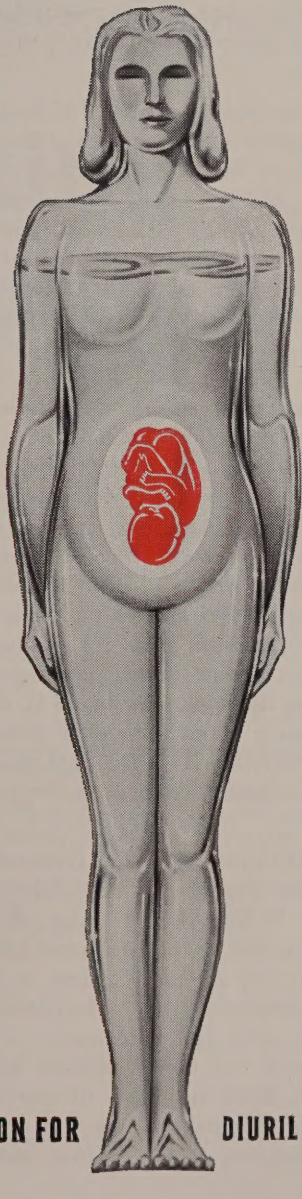

ANY INDICATION FOR DIURESIS IS AN INDICATION FOR DIURIL

The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Textbook of Pathology: With Clinical Applications, by Stanley L. Robbins, M.D. ($18.00, illustrated, *W. B. Saunders Company, Philadelphia 5, Pa.)* It has been written for students of clinicians with three major goals in mind. First, that the subject matter be presented in a logical, concise and readable fashion, devoid of distracting details. Second, that since pathology requires familiarity with the normal structure and functions of organs, that the major relevant normal features of a tissue or an organ will be briefly cited before the pathology is discussed in order that the reader's mind be refreshed. And, finally, considerable emphasis has been placed on relating pathology to clinical medicine.

Current Surgical Management: A Book of Alternative Viewpoints on Controversial Surgical Problems, by John H. Mulholland, M. D., Edwin H. Ellison, M. D., and Stanley R. Frieson, M. D., with contributions by 76 American authors. ($10.00, *W. B. Saunders Company, Philadelphia 5, Pennsylvania.)* In addition to Dr. Ellison the other Ohio contributors are Drs. Thomas Boles, Jr., H. William Clatworthy, Robert J. Izant, Arthur James, Robert N. Watman, and Roger D. Williams, of Ohio State University, and Drs. George Crile, Jr., and Donald Effler of Cleveland.

With wider knowledge a book of this type is of service and as the editors say in their Foreword, it is curiously a paradox that writings on surgery in a period of relative ignorance could be dogmatic whereas in the present period of great knowledge controversy is accepted. Possible at the beginning of this century to lay down rules for conduct to meet most situations so that the practicing surgeon had only to do what the book said should be done; the need for thinking about individual problems was reduced to a minimum. That has been changed and this book has been designed to meet that change.

An Atlas of the Commoner Skin Diseases, by Henry C. G. Semon, revised with the collaboration of Harold T. H. Wilson, M. D., color photography originally directed by the late Arnold Moritiz, M. D. ($20.00, 5th edition, *Williams & Wilkins Company, Baltimore 2, Md.)* This Atlas has now completed its 22nd year of existence, a fact which testifies that it is a useful addition to any physician's library. With the object of correcting well-founded adverse criticisms the author has secured the collaboration of Dr. Wilson and the two of them have brought out the fifth edition. It contains 153 plates reproduced by direct color photography from the living subjects with a page of comment on the nature and character of the disease and the points illustrated by the photograph. An excellent desk volume for every physician dealing with general medicine.

DeLee's Obstetrics for Nurses, revised by M. E. Davis, M. D., and Catherine Sheckler, R. N. ($6.00, 16th edition, *W. B. Saunders Company, Philadelphia 5, Pa.)* This revision of the time honored classic maternity nursing text represents a major change, not so much in content as in outlook. In the last edition the authors placed new emphasis on psychological aspects of pregnancy. This revision progresses toward the recognition of the indivisibility of the functions of the mind, the body and the emotions throughout the child-bearing experience. There is also an effort to deemphasize the pathological aspects of pregnancy.

Synopsis of Obstetrics, by Jennings C. Litzenberg, M. D., revised by Charles E. McLennan, M. D. ($6.00, 5th edition, *C. V. Mosby Company, St. Louis 3, Mo.)* This edition has been revised by Charles E. McLennan, M. D. of Stanford University and he has introduced important advances in obstetrical thought and practice which have become rather widely accepted in recent years and has deleted whatever appeared outmoded.

Blood and Bone Marrow Patterns, by G. D. Talbott, M. D., Elmer R. Hunsicker, B. S., and John Li, M. D. ($12.00, *Grune & Stratton, Inc., New York 16, N. Y.)* This is an atlas of color photomicrographs showing the blood cell patterns as seen by bone marrow smears in the various abnormal conditions. An excellent reference work for any laboratory.

Optics: The Science of Vision, by Vasco Ronchi, translated by Edward Rosen. ($10.00, *New York University Press, New York 3, N. Y.)* This book presents a revolutionary approach to the whole concept of optics which redresses the balance of the science after centuries of its dehumanization by mathematics and physics. It incorporates the validity of subjected measurement after totally reorienting the subject. It challenges the mathematical concept of optics and goes beyond ophthalmology.

Gynecologic Therapy, by William Bickers, M. D. ($4.25, *C. C. Thomas Publishers, Spring-*

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field, Illinois.) This book has been born out of the apparent need for interns and residents who are confronted for the first time with the responsibility for clinical diagnosis and treatment of gynecologic patients. The clinical history, the physical findings, the laboratory diagnostic tests and the therapeutic regimes are presented in the style of the authority of the best opinion of the day.

The Chemistry and Biology of Purines: A Ciba Foundation Symposium, by G. E. W. Wolstenholme, M.D. and C. M. O'Conner. ($9.00, *Little, Brown and Company, Boston 6, Mass.)* The study of purines has proceeded until recently along two lines, from the approach of the synthetic chemist and the viewpoint of the biochemist. Now, with an exchange of views a collaborative reorientation is producing valuable results. This symposium therefore is an important record of the current thought on purines voiced by workers in both disciplines. Recent advances have been made in the biosyntheses of nucleic acid, and the knowledge gained in elucidating this problem opened the prospects of fundamental research in therapy. Considerable progress has also been made in the enzymology of the purines and their complex derivatives. One or two drugs of some clinical value have already been discovered as a byproduct of this particular line of investigation.

Blood Tests In Mental Illness: Papers and Discussion Presented at the Annual Scientific Conference of the Brain Research Foundation, by Frederic Gibbs. (Apply. *Brain Research Foundation, 600 S. Michigan Ave., Chicago 5, Ill.)* This 1957 Scientific Conference provided an opportunity for those interested in Dr. Akerfeldt's work and engaged in simple studies to consider his findings and compare them with their own and consult together regarding the relationship between certain disorders of body chemistry and mental disease.

The Person With Epilepsy at Work: Report 36, formulated by the Committee on Psychiatry and Industry. (25 cents, *Group for the Advancement of Psychiatry, 1790 Broadway, New York 19, N. Y.)* It gives the latest thought to the problem of convulsive seizures and the employment of these million and a half of our citizens, so afflicted, in industry. It is a part of the general consideration of the employment of the physically handicapped.

A Woman Doctor Looks At Love and Life, by Marion Hilliards. ($2.95, *Doubleday and Company, New York 22, N. Y.)* The chief of obstetrics and gynecology at the Woman's College Hospital in Toronto is the author for this manual for women. It is designed to help women to find health knowledge which leads to inner peace and successful zestful living. Whether a woman is frightened or simply perplexed or bothered by her problems the author gives her outspoken advice and realistic answers from her authoritative point of view, both as a woman and as a physician. On the other hand it is not a series of sermons. It is lively, written of case histories and anecdotes.

The Adrenal Cortex, by I. Chester Jones. ($7.00, *Cambridge University Press, New York 22, N. Y.)* The various products of the adrenal cortex play an essential part in the functioning of living creatures and very much has been learned about this organ since the time some 58 years ago that your reviewer was studying the effects of this organ's removal on the gasseous exchange of the cat. It has long been a major subject of study and experimentation for endocrinology. This is the first monograph to give a comprehensive account of the workings of the cortex in all of the various biological species among the vertebrates.

Rheumatic Diseases, Rheumatism and Arthritis, by Henrich G. Brugsch, M. D. ($10.00, *J. B. Lippincott Company, Philadelphia 5, Pa.)* The chief of the Arthritis Clinic in the Boston Dispensary has given us an up-to-the-minute practical comprehensive work on the overall management of the patient with joint disease. It covers as well etiology, diagnosis, and the clinical picture and prognosis of each disease discussed. For the purpose of this book, the diseases which are known to be definitely of rheumatic origin have been separated from the nonrheumatic, separate chapters have been devoted to the so-called collagen diseases and then such things as bursitis, neuritis and ruptured intervertebral disc and other bone diseases.

For Teen-Agers Only: The Doctor Discusses Marriage, by Frank Howard Richardson, M. D. ($2.95, *Tupper and Love, Inc., Atlanta 2, Ga.)* This is a private series of talks with young people who are facing, or should be, the subject.

Signs and Symptoms, Applied Pathological Physiology and Clinical Interpretation, edited by Cyril Mitchell MacBryde, M. D. ($12.00, 3rd edition, *J. B. Lippincott Company, Philadelphia 5, Pennsylvania.)* This text approaches diagnosis in the same way that most of us do, through the analysis and interpretation of presenting signs and symptoms. In each chapter a major symptom is discussed. The mechanism of its production clarified by the light thrown upon it by anatomy, physiology, pathology, chemistry or psychology, its correlation with other symptoms and the physical

(Continued on Page 1007)

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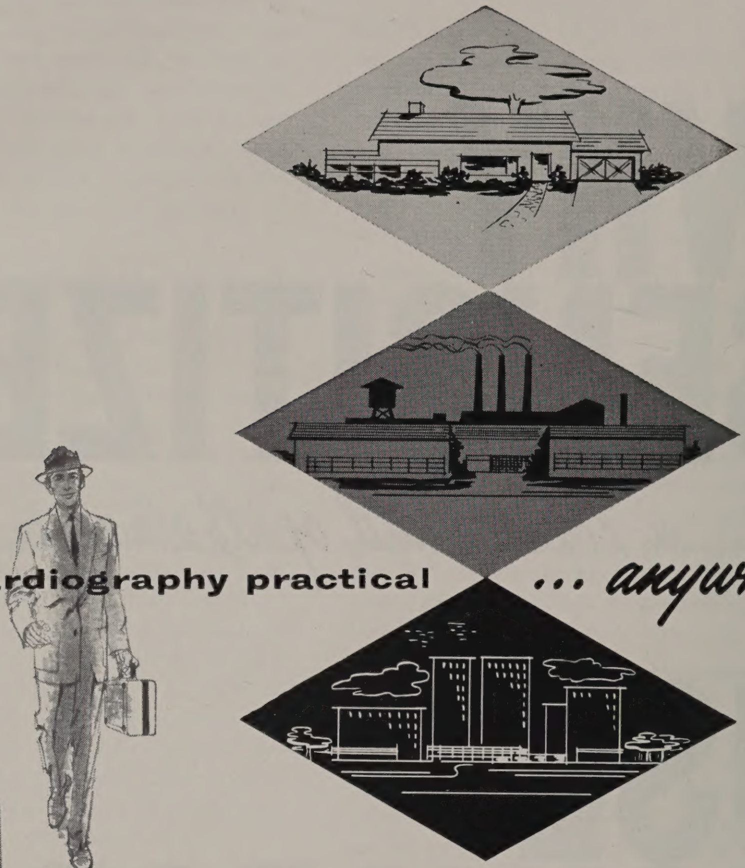

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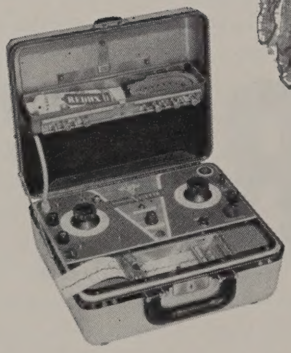

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(Continued from Page 1004)

and laboratory findings described. The book has been thoroughly revised and brought up-to-date in all chapters.

Hutchison's Clinical Methods, by Donald Hunter, M. D., and R. R. Bomford, M. D. ($6.00, 13th edition, *J. B. Lippincott Company, Philadelphia 5, Pa.)* This guide has been servicing physicians and students for the past 60 years. This edition has been condensed by about 20 pages but nevertheless brought completely up-to-date and still serves a useful purpose for which Sir Robert Hutchison intended it.

Fundamentals of Immunology, by William C. Boyd. ($10.00, 3rd ed., *Interscience Publishers, New York 1, N. Y.)* This book reflects the enormous advances that have been made recently in the subject. It gives a clear understanding of the basic principles of immunology and is of value not only to the student but to the research worker and to the physician practicing in this field.

Atlas of Clinical Endocrinology; Including Text of Diagnosis and Treatment, by H. Lisser, M. D., and Roberto F. Escammilla, M. D. ($18.75, illustrated with 148 plates free in color, *C. V. Mosby Company, St. Louis 3, Mo.)* It is intended to give busy practitioners more knowledge about the intricacies of steroid chemistry and the details of animal experiments that are pushing back the frontiers of our ignorance in this field and it is intended also for those who would like to understand more about the application of what we know to human ecology. The authors with their extensive experience present most useful examples from out of their storehouse and in this way bring us a book for clinicians endorsed by E. Perry McCullagh, M. D., of the Cleveland Clinic.

Blood Transfusion in Clinical Medicine, by P. L. Mollison, M. D. ($9.00, 2nd edition, *Charles C. Thomas Publisher, Springfield, Ill.)* In this new edition most of the chapters have been rewritten to take into account the many advances of the last five years and also much of the material has been rearranged which seems appropriate in the light of new discoveries.

Modern Therapy in Neurology, by Francis M. Forster, M. D. ($12.00, *C. V. Mosby Company, St. Louis 3, Mo.)* The appearance of this book is a milestone in the progress of our fight against the disease. Up to recent times the specialty of neurology has been justly criticised for its lack of interest in treatment. It was the concensus that neurology was concerned mainly with the intricacies of localization of lesions and that after a diagnosis had been established there was usually no effective therapy. In recent years as the diseases of the nervous system began to have a biochemical and immunological background it has been possible to develop a considerable armamentarium and this book presents the latest with each chapter being in the hands of an outstanding man in the field. For instance, the use of tranquilizing drugs in neurology is well discussed by Howard D. Fabing of Cincinnati.

Industrial Toxicology, by Lawrence T. Fairhall. ($10.00, Second Edition, *Williams and Wilkins Company, Baltimore 2, Md.)* This encompasses in one compact reference book all of the classified information and discoveries of importance that have been made available. This edition also gives a completely revised digest of the currently available knowledge in this field.

Voluntary Health Insurance in Two Cities: A Survey of Subscriber-Households, by Odin W. Anderson and staff, National Opinion Research Center. ($5.00, *Harvard University Press, Cambridge 38, Mass.)* This determines scientifically the impact of uninsured illness on the use of services and facilities for sickness. The 200 drug companies who sponsor the foundation backed this in order to give underwriters data with which to measure accurately the accomplishments of present-day hospital and medical prepayment and insurance coverage.

565 Industrial Compensation Decisions, by Richard F. Gonda, J. Arlen Marsh and Ivan W. Louis. ($12.50, *Occupational Hazards Magazine, 812 Huron Road, Cleveland 15, Ohio.)* This work presents a condensed version of Workmen's Compensation cases completely cross-indexed for ready reference.

The Diagnosis and Treatment of Endocrine Disorders in Childhood and Adolescence, by Lawson Wilkins, M. D. ($17.50, 2nd edition, *C. C. Thomas Publisher, Springfield, Ill.)* This book has been written to help the clinician to understand, diagnose and treat these conditions. In recent years the medical profession has become much more familiar with the subjects through the wide publicity accorded recent advances. Now there is an earnest desire for more complete information concerning the chemistry and physiology of hormones and for an evaluation and interpretation of some of the newer work.

Benjamin Waterhouse and the Introduction of Vaccination; A Reappraisal, by John B. Blake. ($4.00, *University of Pennsylvania Press, Philadelphia 4, Pa.)* A revelation in the light of fresh material never before used in this connection, the lectures on the History of Medicine at Yale were through the traditional picture of Waterhouse.

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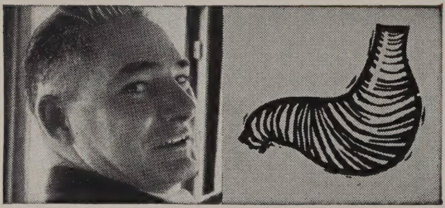
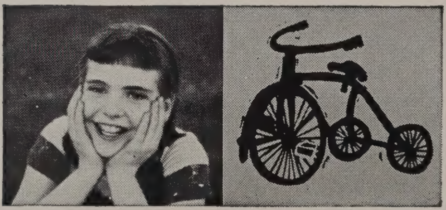
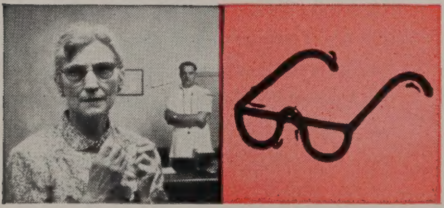


Other tranquilizers added to PN's g. i. discomfort (he has ulcers). But now his doctor has him on ATARAX because (+) it lowers gastric secretion while it tranquilizes.



Asthmatic JL used to have frequent tantrums followed by acute bronchospasm. Her family doctor tranquilized her with ATARAX because (+) it is safe, even for children.



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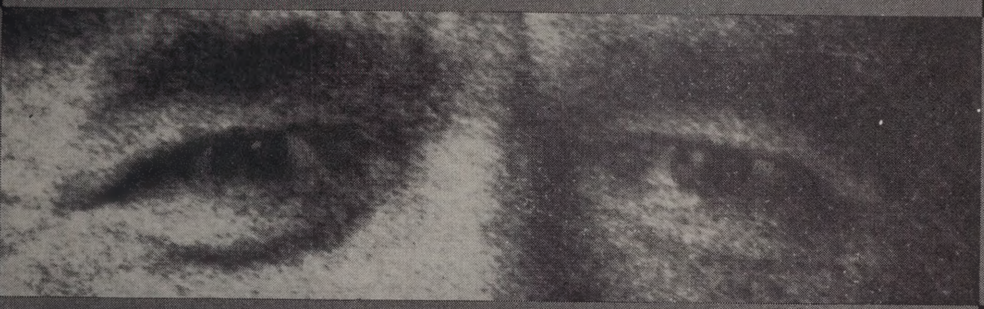

what are the 7 "dont's" of office psychotherapy?

(1) Don't argue—let patient "talk out" his troubles. (2) Don't counsel—help him solve his own problems. (3) Don't be hostile—allow patient to express hostility without reciprocating. (4) Don't be unsure—stress significance of normal or abnormal physical findings in relation to symptoms. (5) Don't be too reassuring—overoptimism may suggest you take the symptoms too lightly. (6) Don't approve or censure. (7) Don't be too credulous—patients' words may conceal hidden meanings.

Source—Hyman, M.: Some Aspects of Psychiatry in General Practice, GP *16*:83 (Oct.) 1957.

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*Bauer, H. G.; Seegers, W.; Krawzoff, M., and McGavack, T. H.: A Clinical Evaluation of Ectylurea (NOSTYN®), in press.

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Social Security for Physicians . . .

Material Pro and Con on This Subject in This and September Issues of *The Journal*; Poll To Determine Opinion of OSMA Members Will Follow

THE HOUSE OF DELEGATES of the State Association, at the April Annual Meeting in Cincinnati, adopted a resolution calling for a poll of OSMA members on the question of whether or not physicians should be included in the Federal Social Security Program. This poll will be conducted during the month of October.

The House of Delegates further directed that *The Journal* should present in each of three issues (July, August and September) selected material and comments both for and against the inclusion of physicians under Social Security. The first of this material was presented in the July issue, beginning on page 868. Following is additional material on both sides of the question.

Members are advised that opinions expressed by the writers are those of the authors and do not necessarily reflect opinions of officials of the OSMA or staff members of *The Journal*.

Arguments For

"THE Case for Social Security" was the subject of an article authored by Dr. H. Feilding Wilkinson in the October, 1957, issue of *Medical Economics*. The article read as follows:

Since 1935, when the Social Security Act became law, the medical profession has stood at the top of the list of those opposed to it. The profession is still at the top. But it stands there entirely alone—the sole major occupational group in the country not now covered by Social Security.

Do we doctors *like* being alone? Apparently nearly three out of five of us think we do. The most recent national survey (reported by *Medical Economics* in September, 1956) showed 59.8 per cent of self-employed physicians opposed to compulsory coverage for themselves.

But is also showed 40.2 per cent in favor. So more than two in five of us *don't* like being alone. That's a substantial minority. And it has substantial economic reasons for the stand it takes.

The same can't be said, in my opinion, for the doctors who oppose Social Security. After listening to a good many of them, I'd say that their objections are based more on myth than on fact. And they're often so glibly stated—even when one of them virtually contradicts another—that one suspects they've been heard or read somewhere and that they're being parroted without benefit of thoughtful consideration.

What are some of these often repeated objections to Social Security? I'll state them in the doctors' own words—and, at the same time, I'll

(Continued on Page 1011)

Arguments Against

By Charles W. Pavey, M. D., Columbus, Ohio

THERE are a great many cogent reasons why the medical profession should shun inclusion in the Social Security system. These reasons are ethical, philosophical and practical but none are as important and meaningful to the medical profession as the inescapable association between Social Security and socialized medicine.

Those who argue for socialized medicine contend that it is essential to the nation's health because they say the average family cannot afford to make financial provisions for their medical care and hospitalization. This despite the fact that such provision would take a smaller part of the family budget than liquor, automobiles, amusement and other far less essential things. Most of the medical profession deny this contention and claim that the average American family does not need governmental financial assistance to pay for medical care and they contend furthermore that such methods constitute socialized medicine and are not in the public interest. Most of us will agree that this is correct. On the other hand, it is utterly inconsistent to argue that socialized medicine is bad but socialized power, transportation, manufacturing or insurance is good. If the medical profession demands inclusion in the Social Security system then we can be assured that the politicians will point out to us that we don't object to socialism when we are the beneficiaries and they are sure to say that our objections to socialized medicine are obviously insincere and

(Continued on Page 1011)

Arguments For (Cont'd)

tell you why I believe these doctors are misinformed about the Social Security system.

Is It Fraudulent?

"It's financially bankrupt, a fraud."

Those opposed to Social Security back up this charge by alleging that the contributions taken in are being spent "right and left" by the government. Social Security, they say, is just an excuse for unbridled Government spending—"and there'll be no money left when growing numbers 65-year-olds become entitled to it."

No money? Financially bankrupt? Well, there's nearly $23 billion surplus in Government bonds in the Old Age and Survivors Insurance Trust Fund. If ever there *were* a dangerous drain on the fund, Social Security tax rates could easily be raised. All it takes is a vote of Congress.

Meanwhile, far from being dribbled away, the funds already collected are constantly drawing interest. They've already earned some $3 billion in interest.

Actuaries Were Right

"It's actuarially unsound."

Actuaries are the mathematicans who use mortality tables, loss ratios, and other data to determine rates for various types of insurance. In the case of Social Security, they did their job well: The size of the fund's current surplus, the changing rates of income and outgo, are falling into almost the exact pattern that was anticipated more than twenty years ago.

I'd call that actuarial soundness rather than the reverse.

"It's a Government handout."

Since 1936, Social Security has taken in some $20 billion more than it has paid out. This sum, plus about $3 billion in interest, is invested in U. S. bonds. These are the same bonds, remember, in which your private insurance company has invested a good percentage of its own reserve funds.

If a private insurance carrier had a surplus of $23 billion out of a total income of $30 billion over a twenty-year period, the cry would be "robbery," not "handout."

But lest you conclude it *is* "robbery," let me explain something else:

25-Year Reserve

The $23 billion excess is necessary as a reserve fund. It will be needed before the Social Security fund reaches a point of balance between income and outgo. During the next twenty-five years, all those extra billions will be used up in payments to

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Arguments Against (Cont'd)

based on selfishness rather than on any ethical or philosophical objections to socialized medicine or Socialism per se. They are sure to say "you doctors are quick to ask for government security but you would deny to others the equally important government medicine." And when they do say that, it will be a hard argument to counter. It behooves us to note also that most of the organized groups, such as The Physicians Forum, urging inclusion of M. D.'s in Social Security have also advocated socialized medicine. The relationship between socialized medicine and inclusion of M. D.'s in Social Security seems to be lost on many physicians but we can be certain that the proponents of socialized medicine understand it quite clearly.

The Door Swings in

Too many doctors advocating inclusion do not fully understand that they are proposing a dangerous step that will be forever irrevocable. If further and more extensive experience would prove beyond doubt that inclusion might be desirable, we can always get in but once we are in, no matter how grievous an error it may prove to be, we can never get out. Similarly many physicians are not fully aware that there is no contract nor any actual ceiling on premiums. There is a projected plan for graduated increases up to a certain point but this proposed scale has already been altered several times to allow for additional dubious benefits which will be increased every election year and it is entirely possible that the rate will go to 10 per cent of the first $20,000 of earnings. If this should happen the average doctor would be paying $2000 per year for less insurance than the laborer with a larger family would be getting for $300 or $400. On top of that benefits will be determined by Congress from year to year. There is no contract. No one knows how much his premium will buy in benefits until he goes to collect. This is Communism in action! Taking from each according to his means and giving to each according to his need! A fundamental principle of Marxism.

Changing the Rules

The Social Security Administration has already "welshed" on its promises a number of times. In 1935 the act assured the 33,000,000 people required to pay into the fund a permanent coverage after five years. In 1939 this was arbitrarily increased to 10 years. The 1935 act guaranteed the taxpayer or his estate his money back if he did not get it in annuities. In other words the original act was in effect an enforced savings

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Arguments For (Cont'd)

new beneficiaries. After that, as tax rates rise according to schedule, the fund will be completely carrying itself.

"I can take care of myself without Social Security."

Are you sure? In Los Angeles, over 100 doctors and other members of medical families are being taken care of by the Los Angeles County Medical Association. A similar situation exists in New York City. Undoubtedly, these indigent physicians once assumed that *they* could take care of themselves.

Better Than Charity!

If it weren't for the out-of-pocket charity of their colleagues, such men—or their widows and children—might be on public assistance rolls. Charity has been a godsend for them. But how much more of a godsend would Social Security have been!

It's fine to be proud of one's independence. But as a pretext for rejecting Social Security, such pride seems a trifle naive. The retired bank president who lives next door isn't too proud to accept his $108.50 a month. The business executive who died last year would be glad to know that his already well-off widow and children are getting Social Security payments of $200 a month.

Would your widow be too proud to take such payments? Don't be too sure. Don't be too quick to deny her and your children 2,400 non-taxable dollars a year.

Protects Your Heirs

"It's a gyp: You get nothing if you die before 65."

Of course *you* don't. But your beneficiary gets plenty. When a person who's covered by Social Security dies—whether before or after 65—his survivors can receive up to $200 a month. Even his parents, if dependent, can get substantial monthly benefits as long as they live.

This feature alone can be worth up to $35,000. Is that bad?

"It's a gyp: You get nothing after 65 unless you quit working."

True, up to a point. But those who protest fail to understand the real purpose of Social Security. It's not a substitute for private retirement plans. It's to save people from the humiliation of going on public relief rolls. In addition, it's intended to furnish a foundation upon which to build your own retirement fund—*if* you so desire.

The average age of retirement under Social Security at present isn't 65; it's 69. Obviously,

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Arguments Against (Cont'd)

plan and as such far more defensible than the present plan with its built-in politically inspired vote buying aspects. This promise was kept in a half million cases and then in 1939 Congress wiped out this part of the agreement to 33,000,000 others who had been given the same promise. They were not allowed to withdraw from the game now that the rules were changed and in the ensuing 13 years seven million of their number died without refund or pension payments.

Anyone interested in being honestly and accurately informed on Social Security should read a little inexpensive book by Dillard Stokes entitled *Social Security Fact & Fancy* (Henry Regnery Company, Chicago, $4). In view of the fact that Social Security "premiums" might very well cost you from $8,000 to $40,000 in the next 20 years depending on rates and benefits yet to be determined you can hardly afford to cast a vote without first being informed.

The argument so often presented that since "Social Security" must inevitably be subsidized by the income tax and since we help pay for it anyway we might as well get in on it is comparable to saying that since we give to the Salvation Army we ought to get in the line for a free basket of groceries at Christmastime.

The Social Security system as it is presently set up and operated and as is demonstrated by every session of Congress is the most colossal vote buying device in history. To buy votes with private funds is a crime. To buy them with public money is rapidly becoming a standard order of procedure among certain legislators and if we allow ourselves to become the recipients of such covert bribes we jeopardize our positions as members of an idealistic and honored profession.

One of the often heard arguments in support of inclusion of doctors in Social Security is that "it's just insurance." Actually the Supreme Court has held on the representations of the government's own lawyers (May 24, 1937) that it is not insurance but charity. The so-called premiums are actually income tax on the worker, excise tax on the employer and the disbursements are relief payments.

"Socialized" Security

Charity and governmental Social Security are intended for those who cannot and those who will not make provision for their own old age. We as physicians fit neither of these groups. If we are indeed the proud, independent, individualistic breed we represent ourselves as, to the public, if we really hate Socialism for the evil that it is,

(Continued on Page 1014)

Low Dosage

KYNEX*

Sulfamethoxypyridazine Lederle

for G.U. Infections

Only
One
tablet
a
Day

Unusual Antibacterial and Anti-infective Properties—More soluble in acid urine[1] . . . higher and better sustained plasma levels than any other known and useful antibacterial sulfonamide.[2]

Unprecedented Low Dosage—Less sulfa for the kidney to cope with . . . yet fully effective. A single daily dose of 0.5 to 1.0 Gm. maintains higher plasma levels than 4 to 6 Gm. daily of other sulfonamides—a notable asset in prolonged therapy.[2]

Dosage: The recommended adult dose is 1 Gm. (2 tablets) the first day, followed by 0.5 Gm. (1 tablet) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours.

KYNEX—WHEREVER SULFA THERAPY IS INDICATED

Tablets: Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

Syrup: Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

references:

1 Grieble, H.G., and Jackson, G.G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958

2. Editorial: *New England J. Med.* 258:48-49, 1958.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle

*Reg. U. S. Pat. Off.

Arguments For (Cont'd)

many Americans forgo benefits for several years for the privilege of earning more while they can. Nor do you hear complaints from such persons, even though many of them have been paying into the fund for over twenty years. They'll get theirs back in time with plenty of interest—and they know it.

From 65 to 72, incidentally, you can earn up to $1,200 a year and still get full benefits. Over 72, you get your Social Security payments no matter how much you earn.

Every Bit Helps

"Benefits are too small to bother about."

Is $162.50 a month for yourself and your wife really so insignificant? Maybe it seems so to the doctor who's a great financial success. But such a doctor may be overlooking this: Those extra dollars are all *tax-free.*

Figure out what that's worth if you're in the higher brackets.

"It's unfair: It allows some persons who've paid in almost nothing to get full benefits."

True, some people have obtained up to $10,000 or $15,000 worth of coverage for contributions of only $75 to $100, while others have contributed far more and received far less. But the same things happen with private insurance. Would you call life insurance unfair simply because the family of a policyholder who dies early gets a greater "bargain" than does the family of a man who goes on living and paying premiums?

Why, then, raise such an argument against Social Security?

'Weakens Character'

"It violates American traditions and ideals."

There are many variants of this charge: "It weakens national character . . . It restricts and threatens individual initiative . . . It destroys self-respect and independence of spirit . . ."

Nonsense! It hasn't done any of these things to those thousands of our fellow-countrymen who, preferring work to benefits, have boosted the average retirement age under Social Security to 69.

Would It Backfire?

"It invites socialized medicine."

This objection stems from some doctors' fears that the public would react thus: "Oh, so you medical people want state-sponsored security, do you? Well, then, we want state-sponsored *medical* security.

Conceivably this could happen. But it's most unlikely. Some 120,000,000 Americans already

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Arguments Against (Cont'd)

then we want no more part of socialized insurance than we do of socialized medicine. A vote for socialized insurance is a vote for socialized medicine.

Among the more vocal proponents of including doctors in Social Security is The Physicians Forum, an organization that has long advocated socialized medicine and that was declared to be a Communist front by the California Un-American Activities Committee. While many doctors profess to be unable to see the connection between Social Security for physicians and socialized medicine we can be sure that the relationship is quite clear to The Physicians Forum and that they visualize such inclusion as an incomparable stepping stone to their real goal of socialized medicine. This is a rather small organization and one might well ask where they got the very large amount of money required for the nationwide mailings they have put out advocating inclusion of doctors in Social Security.

Anyone who can even contemplate this proposal with equanimity must be blissfully unaware of its real nature. Here we have a new type of income tax, a tax on wages or earnings without deductions and in all probability without limit. It is morally certain that the politicians will continue to use Social Security to buy votes which means it will be expanded in all manner of fantastic ways and while the rates are bound to increase what is even more certain is that the base amount will go up and up simply because that will antagonize fewer taxpayers and lose fewer votes. The base may very well be expanded to $20,000 per year or above, and the rate could reach 20 per cent or more as it has in some European and South American Countries.

Welfare (?) State

The Welfare State has never succeeded anywhere. It has nowhere abolished poverty nor raised the health standard of a nation. It undermines morale, limits liberty and tends to destroy thrift and initiative while creating a bureaucratic autocracy. Year after year we must defend ourselves from this monstrous degradation—but if just once we relax our vigilance, just once we let our guard down we are in forever, irrevocably in. We will never again have a chance to vote on it, there will be no chance to rectify our error, no forum for our complaints, we will have joined 55,000,000 others behind the bureaucratic iron curtain forged out of their own complacency and indifference.

The normal insurance program contemplates

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Arguments For (Cont'd)

have some kind of voluntary health insurance. They've turned to voluntary sources for their medical security. Unless these sources fail them, they're not likely to turn away.

There's a far greater danger than that of inviting socialized medicine. It's the danger of permitting the public to conclude that doctors make so much money they can easily take care of themselves without a "paltry hundred or two a month" after they reach 65.

That isn't true—but the public wouldn't know it from the way the medical majority has been acting.

Personally, I think there's going to be a new medical majority before long. The arguments against Social Security are too thin. The economic facts that constitute the argument in favor of it are too substantial.

Two months ago in *Medical Economics,* the director of the AMA Law Department predicted that "Congress will force the medical profession under the Social Security Act on a *compulsory* basis within the next five or ten years."

I wouldn't dispute this. I'd simply ask self-employed physicians to give serious consideration to a two-word question: *Why wait?*

* * *

By Geo. O. Cummings, Sr., M. D.

"I am in favor of Social Security for Physicians," wrote George O. Cummings, Sr., M. D., Portland, Maine, in the December, 1957, issue of *The Journal of the Maine Medical Association.* Dr. Cumming's article reads as follows:

I am interested in securing Social Security for physicians.

I am 66 years old and will not benefit from Social Security unless I can work six quarters.

I receive $135 a month from an annuity with the John Hancock Insurance Company which cost me $500 a year for 25 years, a total of $12,500. If Social Security had been instituted 25 years ago, I would have paid in a total of $5,496.75 and I would receive at the age of 65, $162.80 each month for myself and my wife.

Under my annuity, if I die, my wife will receive a lump sum, the unpaid balance of the principal. Under Social Security, she would receive for life, $81.40 a month if she started to receive payments at the age of 62, and $108.50 a month if she started payments at the age of 65.

Social Security is the cheapest protection that you can buy for you and your wife.

The following quotation is from a pamphlet

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Arguments Against (Cont'd)

premium payments at the rates which will cover anticipated benefit payments, actuarially determined, and operating cost plus some reserve to take care of possible inaccuracies in the actuarial figures but the Department of Health Education and Welfare cheerfully admits that it does not operate on this system and that there is no relationship between what an individual pays and what he may receive. This system will continue to work so long as 50 or 60 million people are paying in and only seven or eight million receiving benefits but this is a ratio that is constantly shifting in the direction of more and more beneficiaries in proportion to the number of taxpayers.

Big Promise — of What?

There is very great risk that the day may come when this tax burden will be utterly insupportable and the hapless taxpayer may finally revolt and when that day comes there is a possibility that those who had anticipated receiving Social Security will instead be notified that lack of revenue precludes the fulfillment of poorly funded promises of previous administrations, or, and what is more likely, they will be paid off at the rate promised them at the time they went into this system with dollars that are so inflated that their buying power will be cut to practically nothing. Social Security as it is at present set up and at present being charged is not insurance at all but nothing more or less than another income tax which the government has tried to make moderately palatable by promising something in return and you will note that we say promising, not guaranteeing. The Social Security officials will admit that none of the money in the so-called trust fund that has been accumulated since the start of this system by the working people and their employers will be available for benefits to them when they retire. Everybody in the group still working will be obliged to depend on future taxes to pay their so-called benefits. The cynical unprincipled argument so often presented as a reason why you should want to be included in Social Security is that you will be paying in at a low rate, lower than it will ever be again, for a short time, and then will be paid back generously with somebody else's money. As Christians and Americans we shouldn't be interested in living our declining years on somebody else's money. What you get without earning someone else must earn without getting, for our government cannot give to any of us what it does not first take away from some of us. Living as a parasite on the earnings of other men's labors is looked upon with considerable disfavor by these

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Faster rehabilitation i

Joint inflammation and muscle spasm are the two elements most responsible for disability in rheumatic-arthritic disorders — and MEPROLONE is the one agent that treats both.

MEPROLONE suppresses the inflammatory process and simultaneously relieves aching and stiffness caused by muscle spasm, to provide greater therapeutic benefits and a shorter rehabilitation period than any single antirheumatic-antiarthritic agent.

MEPROLONE-2 is indicated in cases of severe involvement, yet often leads to a reduction of steroid dosage because of its muscle-relaxant action. When involvement is only moderately severe or mild, MEPROLONE-1 may be indicated.

SUPPLIED: Multiple Compressed Tablets in three formulas: MEPROLONE-2—2.0 mg. prednisolone, 200 mg. meprobamate and 200 mg. dried aluminum hydroxide gel (bottles of 100). MEPROLONE-1 supplies 1.0 mg. prednisolone in the same formula as MEPROLONE-2 (bottles of 100). MEPROLONE-5—5.0 mg. prednisolone, 400 mg. meprobamate and 200 mg. dried aluminum hydroxide gel (bottles of 30).

a

Because muscles move joints, both muscle spasm and joint inflammation must be considered in treating the rheumatic-arthritic patient . . .

MERCK SHARP & DOHME Division of MERCK & CO., INC., Philadelphia 1, Pa.

Rheumatoid Arthritis

multiple compressed tablets

MEPROLONE®

HE FIRST MEPROBAMATE-PREDNISOLONE THERAPY

b

MEPROLONE is the one antirheumatic-antiarthritic that exerts a simultaneous action to relax muscles in spasm and to suppress joint inflammation . . .

c

Therefore, MEPROLONE does more than any single agent to help the physician shorten the time between disability and employability.

MEPROLONE is a trade-mark of Merck & Co., Inc.

Arguments For (Cont'd)

"Nine Sound Reasons," published by the Committee on Social Security for Physicians, The Physicians Forum, 510 Madison Avenue, New York 22, New York. Anyone who desires more information should obtain the pamphlet from them. It is clear and brief.

1. Old Age and Survivors Insurance (OASI) offers better value for your insurance dollar than any private company in the United States. It provides three-way coverage—life insurance, disability benefits and retirement income. To get the same benefits from private companies can cost from $6,500 to $25,000 more.

2. Among the 70,000,000 Americans under Social Security are dentists, lawyers and other self-employed professionals; bank presidents and business executives in top-income brackets; physicians employed by hospitals, medical groups and private industry. Why should self-employed physicians be excluded?

3. OASI coverage requires no physical examination. No one is excluded or asked to pay higher premiums because of existing disability, ill health, occupational hazard or advanced age .

4. OASI benefits are entirely tax free, and are paid without regard to income derived from investments, private insurance or annuities. These benefits could provide a substantial foundation in planning your family's security.

5. OASI contribution rate is uniform for all self-employed persons, regardless of other income or age. You pay a fixed rate only on the first $4,200 of earned income. For years 1957-1959, the rate is 3⅜%—or a maximum of $141.75 annually.

6. For the young doctor, survivor's benefits of OASI are especially important. In the event of his death, his widow and children under age 18 receive a maximum of $200 a month.

7. For the older doctor (including those practicing at age 65 or over), OASI retirement benefits are a welcome addition to his retirement income. At age 72, he would get full benefits, regardless of

Cost of Retirement Benefits Under OASI*
Compared With Private Insurance Companies
(For husband and wife)

If you enter OASI in 1958 at age of	You would pay OASI taxes totaling (by age 65)	Same benefits from private companies cost you at least	Your loss because of exclusion from OASI
30	$8,174.25	$14,700	$ 6,525.75
35	6,835.50	16,300	9,464.50
40	5,496.75	18,000	12,503.25
45	4,158.00	19,900	15,742.00
50	2,882.25	22,000	19,117.75
55	1,764.00	24,400	22,636.00
60	803.25	26,000	25,196.75

*Cost of OASI also covers survivors insurance and disability.

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Arguments Against (Cont'd)

self-same people that are advocating that we adapt this self-same idea to Social Security.

Leaning on Progeny

We should like to also call your attention to the fact that simply making this swindle legal by no means has made it moral. Just ask yourself does this generation have any moral right to place the burden of its future on the shoulders of its own sons and daughters? This is a moral problem even more than a financial one. Our children are destined to be the innocent victims of our decision, and even though they may pass on a burden to their children thereby doing to their progeny what we are doing to ours, we can scarcely be proud of being a part of a generation which, by its example, teaches its children that such an act is right.

For anyone to vote himself benefits that he knows in advance he will not pay for is comparable to charging something to someone else's account without their knowledge or consent. That any member of the medical profession would attempt to gain for himself benefits to be paid for by strangers as yet unborn seems utterly incompatible, with the high ethical standards that we presume to maintain in our professional lives.

It seems quite apparent that the architects of Social Security have engineered it in such a way that we must all ultimately become wards of the State whether we want to or not and their program is aimed at someday taking away from us all of our earnings and giving us back only enough to keep us slaves to the ever-increasing power of the State. As a matter of fact we are already far closer to the realization of that aim than most of us want to admit.

* * *

By Ben Arnoff, M. D.,
Columbus, Ohio

The doctors of Ohio have before them for consideration two plans for retirement, disability benefits and benefits for the protection of their families in case of death.

PLAN NO. 1
THE SOCIAL SECURITY PLAN

What are the benefits?

A. **Retirement**—at age 65 would receive $108.50 per month.

1. **If**—you paid into the fund for at least 1½ years.

2. **If**—you earn less than $80 per month.

B. **Survivors benefits paid to widow.**

1. If there is one child under 18—benefits to be paid only until child is 18.

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Arguments For (Cont'd)

his earnings. At age 50 or over, retirement benefits are now provided for the completely disabled.

8. Roughly 35 per cent of all self-employed physicians listed in the AMA Directory have at least some credited earnings under OASI, according to a sample survey by OASI in 1955. They acquired these credits either before entering private practice or by part-time employment while in private practice. Also, physicians who served in World War II are entitled to OASI credits. These credits may be lost or the benefits curtailed unless self-employed physicians are included under the Social Security law.

9. OASI benefits have been adjusted to cushion the effects of inflation. In 1940, maximum monthly benefits for an individual were just over $40. Today, they are $108.50—an increase of more than 150 per cent! Private insurance companies have not kept pace with inflation.

* * *

By Charles S. Higley, M. D.

The following article was published in the November, 1957, issue of the *Cleveland Academy of Medicine Bulletin.* It was written by Dr. Charles S. Higley:

The physician in private practice stands alone in his private economic affairs today. Current figures show that of the 65 million employed and self-employed individuals in this country 59 million are now covered by Social Security. Of the 6 million not covered, 3½ million have earnings insufficient to qualify and the majority of the remainder are covered by other retirement programs. Self-employed physicians are the only remaining professional group not receiving the benefits of coverage by Social Security—now known as Old Age and Survivors insurance or OASI. All other self-employed professional groups including lawyers and dentists are a part of the program at their own request.

This omission of physicians is no accident. It is the result of vigorous and expensive lobbying by the American Medical Association. Its House of Delegates again in June 1957, in a spirit of "father knows best," decided that its members did not, or should not, desire to be included in OASI and ignored the requests of a number of state delegations to change its position. The fact remains that thousands of physicians in private practice, who have given serious thought to this matter, have come to the conclusion that OASI is a bargain as a part of their disability and retirement programs.

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Arguments Against (Cont'd)

2. If there are more than two children under 18 years of age—no benefits paid for more than two children.

3. If widow remarries benefits are discontinued.

4. If childless widow or no children under 18 years of age—no benefits paid until widow reaches age 62.

5. If no survivors—**no benefits paid to anyone** (unless parents are dependent on deceased). **All monies paid into fund become the property of the government.**

C. **Disability benefits.**

1. If under specified circumstances you become permanently and totally disabled certain benefits will be paid.

But, the "issuing company" has the sole right to change any of the above "benefits" at any time without any notice and the "insured" has to accept any change and without any recourse and **has no right to drop out of the plan once it is accepted.** However the "issuing company" can deprive the individual of any benefits it so desires. Furthermore the amount of "benefits" depends also on the amount of money available in its funds for disbursement at any given time. The sole judge of any controversy over the disbursement of any "benefits" shall be the "issuing company"—and its verdict is final.

What does it cost?

1. The cost will vary—increasing ¾ per cent every five years until 1975 and from then on it will be $267.75 per year.

2. All men becoming doctors in 1975 will pay $267.75 per year until such time as the "issuing company" shall decide to raise the rates.

3. The "issuing company" has the sole right to change this rate at any time it so desires without showing cause, without increasing "benefits" and the insured has no recourse and no right to cancel policy once it is issued.

4. **There is nothing implied in this contract to guarantee any payments to anyone nor to guarantee that the rates will be fixed as of date of issue.**

5. In order for the above "benefits" to become effective, not only every physician in the State of Ohio must pay the "premiums" prescribed but also every physician in these United States—whether or not he desires such a policy. **Further once the plan is accepted it cannot under any circumstances be cancelled by the insured.** The

(Continued on Page 1020)

Arguments For (Cont'd)

And other thousands of physicians are happily covered by OASI through positions in clinics, schools or in industrial practice. Indeed, I know several physicians who have taken minor positions solely for the purpose of securing coverage.

What does the record show in regard to the desire of physicians to be included? A poll taken by the Academy in 1955 showed 394 in favor of voluntary inclusion, 101 in favor of compulsory inclusion and only 39 against any inclusion. The Ohio State Medical Association poll in 1954 showed 2,459 in favor of voluntary inclusion and 2,441 against. An analysis of polls taken in 40 State Medical Societies published in the *JAMA*, 61:1162 (July 21, 1956) showed a majority of the membership in favor of voluntary inclusion in 30 of the 40 states reported. This appears to be conclusive evidence that the House of Delegates of the AMA is not representing the will of the majority of the membership in this matter.

There is not sufficient space to give a thorough analysis of the provisions of OASI here, but briefly the maximum yearly cost to self-employed is now $141.75. For this one would receive retirement disability and death benefits at a fraction of the cost of that obtainable through private insurance. For the young physician, survivors' benefits in event of death, for his widow and children under 18, would be a maximum of $200 a month. For the older married doctor, the retirement and disability income would amount to $162.80 monthly for life subject to restriction at age 65 but unrestricted at age 72.

The entire country has long since accepted OASI as a reasonable and essential part of our economy. Can 59 million people be wrong and the AMA right with regard to this? Is the individual doctor to have a say in this matter of importance to his personal finances or is this a question which the AMA should decide for him?

American Academy of General Practice Schedules Program on Infections

Six medical schools will send top speakers to the Second Annual Symposium on Infectious Diseases. The one-day symposium, jointly sponsored by the American Academy of General Practice, Kansas University Medical Center and Lederle Laboratories, will be held Friday, September 19, at Battenfeld Auditorium on the medical center campus, Kansas City, Kan.

Arguments Against (Cont'd)

sole right of cancellation belongs only to the "issuing company."

6. The assessment of $267.75 per year (after 1975) will begin as soon as the degree of Doctor of Medicine is received. This applies whether the individual is in active practice, in training, or in a salaried practice of medicine.

7. This assessment can be changed without notice by the "issuing company" and the increase in the "premium" is binding on every physician in the United States and there is no recourse.

PLAN NO. 2
PRIVATE INSURANCE PLAN

What are the benefits?

A. **Retirement**

1. There are no ifs, no qualifications, no exceptions. At the age of 65 he will receive an amount exactly as contracted for.

B. **Survivors**

1. There are no ifs, no qualifications, no exceptions;
   a. Benefits paid to widows, children as contracted for and specified in contract.
   b. An estate is developed. Someone receives the benefits accrued in accordance with the will of the insured.

C. **Disability Benefits.**

1. There are no ifs, no qualifications, no exceptions.
2. Benefits are paid in accordance with contract.

These benefits are guaranteed and cannot be cancelled by the issuing company as long as premiums are paid. The sole right of change belongs to the insured.

What does it cost?

1. The cost depends on the type of protection needed and desired.
2. The premium is fixed and cannot be changed by anyone while the contract is in force.
3. Participation is voluntary and its acceptance does not in any way bind any other physician in this state or any other state.

Plan No. 1 is not hypothetical, it is the plan offered by Social Security. The statements made are factual without any coloring matter added.

Plan No. 2 is private insurance.

It is inconceivable that any State in the Union would allow and license a private insurance carrier to offer for sale a policy such as outlined in Plan No. 1 with its ifs, ands and buts.

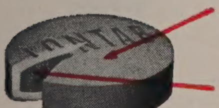
The choice is yours—there is no turning back.

X-RAYS SHOW HOW ONE PYRIBENZAMINE® LONTAB®

relieves allergy all day or all night

The unretouched X-ray films show how Lontabs release medication in the digestive tract. So that the prolonged erosion of the Lontab core could be visualized by X-ray, subject was given 10 Lontabs, each containing 100 mg. of a radiopaque substance in place of Pyribenzamine.

With its unique formulation, the Pyribenzamine Lontab not only relieves allergy symptoms promptly, but sustains relief as long as 12 hours.



Special outer shell releases 33 mg. Pyribenzamine hydrochloride within 10 minutes.

Unique core releases approximately 18 mg. Pyribenzamine hydrochloride the 1st hour, approximately 50 mg. from the 2nd to the 12th hour.

SUPPLIED: Pyribenzamine *Lontabs* – full-strength – 100 mg. (light blue).

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LONTABS® (long-acting tablets CIBA)

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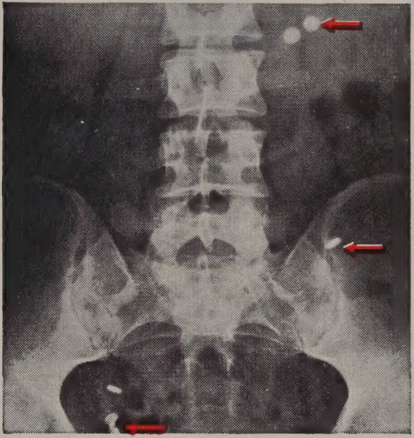
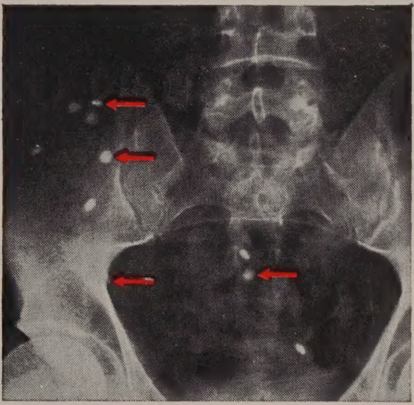
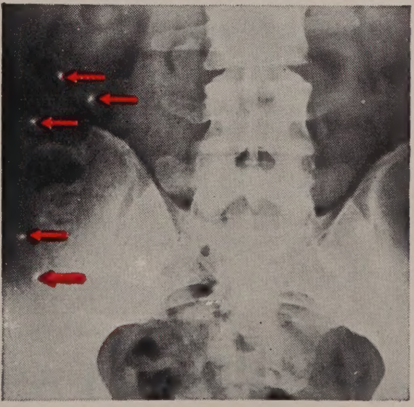
2 hours Lontabs are in the stomach and small bowel. Release of core substance is well under way.



4 hours Lontabs are in the ileum and cecum as core has steadily eroded.



8 hours Lontabs are still visible as substance of core continues to be released.



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In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

THERE IS NO VALID EXCUSE FOR STAYING OUT OF POLITICS

It could be that the fate of the private practice of medicine will be decided by the new Congress which will be elected on November 4 and which will take office in January, 1959.

What can be done about it? What can you do?

The answer's simple: **Get out and work for and elect candidates for Congress who are definitely against any and all socialistic proposals,** including those to extend the activities of the Federal Government into the area of health care . . . for example, the Forand Bill.

If you don't want to be told by us, then heed what a member of Congress, Hon. Ralph W. Gwinn, N. Y. has to say. Here's what Mr. Gwinn wrote in part to a businessman who asked for support for a certain bill to amend the Taft-Hartley Law in which business generally was interested:

"The trouble in Congress is not that we don't know what legislation is needed. We don't have the votes to get it passed. That should be obvious to anyone who knows anything about Washington, but business as a whole either does not know the facts or else refuses to face them.

"What can be done?

"Why do businessmen spend their time and money trying to sell their ideas to Members of Congress already committed or pledged against them?

"For example, what sense does it make for those who want a sound tax program to do nothing to elect sound Congressmen, and then spend millions to try and sell that tax program to a labor-socialist-dominated Congress?

"The horse is already stolen—the lock, the barn door, and the barn too, for that matter.

"If the businessmen of America won't see to it that men are elected committed to restoring constitutional government and law and order in labor-management relations, who else will?

"Business already has thousands of organizations at all levels of society that should have been doing this job. They are the only ones having adequate organizations. They avoid politics. If these organizations continue to rely on resolutions (as to what somebody else should do), 'educational programs,' publicity, going through the motions of lobbying, conventions, Washington representations of all sorts, letterwriting campaigns to the few remaining Members of Congress who agree with them, or to the many Members of Congress who never agree, we might as well resign ourselves to living under a labor government for a long time.

"Business organizations must stop looking for excuses to stay out of politics.

"How many businessmen know exactly how their present Congressmen vote? How many know their Congressman's name?

"It's up to you and others who think as you do to get to work in your congressional district now."

What Congressman Gwinn has said with regard to businessmen and political action applies equally as well to physicians and political action.

Are you preparing to do something between now and November 4 . . . and on November 4 at the polls?

To paraphrase what Mr. Gwinn so aptly said about business and businessmen: **The medical profession and physicians must stop looking for excuses to stay out of politics and must get out and work for those candidates who think as they do on major issues.**

SOUND VIEWPOINT TAKEN BY OHIO ATOMIC COORDINATOR

It's unfortunate that so few men in public office fail to have the vision and common sense expressed recently by William H. Eells, coordinator of Atomic Development Activities in Ohio. Here's what Eells said in an article on Ohio's 1957 atomic energy law, appearing in the magazine *State Government*:

"The Ohio law was patterned after the model bill proposed by the Council of State Governments and the New England Committee on Atomic Energy, but contained a number of changes and additions which were definitely an improvement, and have already proven the seriousness of purpose with which the sponsors considered this legislation.

"A number of the plans that have been brought forward throughout the country since the model bill are lacking in realism.

"As a political scientist with a practical approach, I personally believe that, when establishing any new role for government, you must face the poli-

running noses . . . and other hay fever symptoms

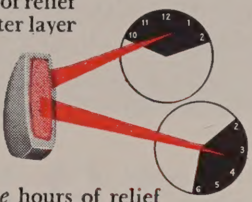
TRIAMINIC stops rhinorrhea, congestion and other distressing symptoms of summer allergies, including hay fever. Running nose, watery eyes and sneezing are best relieved by antihistamine *plus* decongestant action — systemically — with TRIAMINIC.

This new approach frequently succeeds where less complete therapy has failed. It is not enough merely to use histamine antagonists; ideally, therapy must be aimed also at the congestion of the nasal mucosa. Triaminic provides such effective combined therapy in a single timed-release tablet.

TRIAMINIC brings relief in minutes—lasts for hours. Running noses stop, congested noses open—and stay open for 6 to 8 hours.

Triaminic provides around-the-clock freedom from allergic congestion with just one tablet t.i.d. because of the special timed-release design.

first—3 to 4 hours of relief from the outer layer



then—3 to 4 *more* hours of relief from the inner core

Dosage: One tablet in the morning, mid-afternoon and at bedtime. In postnasal drip, one tablet at bedtime is usually sufficient.

Each timed-release TRIAMINIC Tablet contains:

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SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska • Peterborough, Canada tical facts of life. Until the states have had more time to try and evaluate this new role, there should be cooperation with and as little disruption to existing agencies and established lines of authority as possible.

"Although some of the states have first passed legislation dealing with only specific phases of atomic energy, such as the registration of all users of ionizing radiation, I believe Ohio's legislators were wise in establishing a general law setting up the basic machinery needed to look at the problem of future legislation as a whole, and to make a careful study as to actual and practical needs, before enacting new codes and laws.

"For the most part, where possible, future legislation should be based on substantiated and sound data, which in turn should be based on experience."

Physicians, especially those who are directly concerned with the use of radiation in the practice of medicine will, we are sure, say a loud "amen" to this sound statement by Ohio's atomic coordinator.

ETHICS AND THE EMPLOYED PHYSICIAN

Here's a Question which bobs up occasionally:

"Is it ethical for a physician to accept employment under another physician or in a clinic on a part-time basis?"

The Judicial Council of the AMA has this to say on this matter:

"It is not unethical in itself for a physician to accept part-time employment under another physician or in a clinic. The physician so employed and his employer must observe, however, all Principles of Medical Ethics in their relationship with each other and with their patients."

Although the Judicial Council did not in this ruling touch on the legal aspects, they must be taken into consideration. For example, should the employment be in a set-up which violates the Ohio law prohibiting the corporate practice of medicine, then all physicians involved in the set-up would be in jeopardy.

WHY AND HOW MALPRACTICE SUITS HAPPEN

Out in California where the medical profession has been literally plagued with malpractice threats and suits, the California Medical Society has done a lot of research on the causes—the reasons underlying suits.

The following comments from an analysis prepared by that society on why and how malpractice suits happen should serve as a warning to physicians—a preventive; so read them studiously:

"Malpractice suits don't 'just happen.' They have a history—a history that only rarely involves actual malpractice. Their origins almost always lie in the relationships between people, not just in the outward 'facts' of medical care.

"Malpractice suits start, flourish, and flower when patient and doctor do not understand each other—when each, in his own way, is unable to face realistically and directly the feelings that arise in the doctor-patient relationship during the treatment of illness.

"Even real medical mistakes seldom lead to suits if the doctor-patient relationship is based on mature understanding of what people and medicine can and cannot do.

"What makes patients likely to sue or doctors likely to be sued has very little to do with the patient's medical treatment or with the doctor's skill, training or competence.

"The attitudes that make doctors or patients 'suit-prone' are matters of the personality—emotional problems.

"The malpractice suit is a symptom of the breakdown in the doctor-patient relationship. It is a symptom that arises when disappointment and anger dominate. It is a symptom which usually means that both the doctor and the patient have attitudes, expectations and personal traits that make it hard for each to deal with the intense emotions that may arise in both: in the patient when he despairs of health or help; in the doctor when he senses the loss of the patient's admiration or his own self-respect."

NOW IS THE TIME TO BEAR DOWN ON RECORDS OF EXPENSES

That annual roundup of expenses vs. income, known as the income tax return, has probably caused many a physician to murmur, "Next time I'll keep better records of my expenses."

The Internal Revenue Service recently has been bearing down hard on expense accounts. Since a physician's expenses comprise a big percentage of his gross income, expense deductions mean more to him than they do to most taxpayers. Those dollars and fractions thereof paid to the parking lot attendant, the messenger boy and a hundred others count up to real money by the end of the year. Jot it down; keep charge accounts so you'll have a record; instruct your bookkeeper to keep needling you for an accounting.

You'll find the time consumed in keeping records will more than pay for itself when that income tax return rolls around again.

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first relieves apprehension, anxiety and irritability

second restores endocrine balance; relieves vasomotor and metabolic disturbances

third relaxes skeletal muscle; relieves low back pain, tension headache

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Conjugated Estrogens (equine) . . . . . . 0.4 mg.

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Dosage: 1 tablet t.i.d. in 21-day courses with one week rest periods; should be adjusted to individual requirements.

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Deprol is unlike central nervous stimulants

► does not cause insomnia

► produces no amphetamine-like jitteriness

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► has no depression-producing aftereffects

► can be used freely in hypertension and in unstable personalities

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: Each tablet contains 400 mg. meprobamate and 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl).

Supplied: Bottles of 50 scored tablets.

[1] Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. **166**:1019, March 1, 1958. [2] Current personal communications; in the files of Wallace Laboratories.

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Literature and samples on request WALLACE LABORATORIES, *New Brunswick, N. J.*

Washington Roundup . . .

News from the Nation's Capital of Interest to Physicians; Developments in Medical and Health Fields

The problem of viruses that attack Army recruits in epidemic proportions while leaving seasoned veterans untouched has been solved with production of a counteractive vaccine. The viruses had produced a type of influenza uncommon in civilian populations.

* * *

Dr. Warren F. Draper, director of UMW Welfare and Retirement Fund, told American Labor Health Association convention in Washington that Fund never will return to free choice. AMA General Manager F. J. L. Blasingame countered with statement charging "medical interests of the miner and his family have been subordinated to the financial interests of the Fund."

* * *

Constituent units of National Institutes of Health are seeking patients with following diagnoses for admission to 500-bed NIH Clinical Center: Cancer Institute—Acute leukemia, Hodgkins disease without previous therapy, multiple basal skin cancer cells and others; Allergy and Infectious Diseases—Proved or strongly suspected cases of disseminated histoplasmosis; Heart—Patients with hormone-producing malignancies of adrenal gland. Letters of referral and histories may be sent to Director, NIH Clinical Center, Bethesda, Md.

* * *

Public Health Service has contracted with seven pharmaceutical houses for production of chemical agents for possible use against cancer.

* * *

Dr. Richard L. Meiling, former OSMA president and chairman of AMA Military Medical Affairs Committee, was spokesman for AMA opposition to move to down-grade Defense Department's assistant secretary (health and medical) to assistant to the secretary. Dr. Meiling stated in Washington that the AMA has "demonstrated an interest in assuring that the best available medical services are provided for our armed forces in time of war and peace."

* * *

Army plans to vaccinate all active duty personnel with polyvalent flu vaccine that protects against Asian, swine, A., A-prime and B strains.

Offices of Defense Mobilization and the Federal Civil Defense Administration now are merged into a single agency known as Office of Civilian and Defense Mobilization.

* * *

Atomic Energy Commission has set up national network to protect public in event of an accident involving radiation. Radiological teams of physicians, scientists and engineers, trained in safety techniques, would monitor radioactive materials and advise on hazards and control of them.

* * *

Secretary general of MEDICO (Medical International Cooperation), a unit of International Rescue Committee, reports that more U. S. physicians have volunteered for overseas missions than can be used. MEDICO hopes to raise $500,000 by public subscription to send six medical teams to Southeast Asia to set up clinics, according to the secretary-general, Dr. P. D. Comanduras.

* * *

Internal Revenue Services has liberalized interpretation on regulations relating to costs of schooling mentally retarded children and keeping them in institutions, now holding that full cost is deductible for child in an institution as a medical expense, and full cost of enrollment in special school, including meals and lodging, is deductible if child is enrolled for alleviation of mental or physical handicap.

* * *

Public Health Service has promoted to rank of assistant surgeon general Harry G. Hanson, who activated Robert A. Taft Sanitary Engineering Center in Cincinnati four years ago and has headed the center since then.

* * *

American Red Cross estimates it has provided $57 million worth of blood fractions to physicians throughout U. S. for use in therapy and research since 1944.

* * *

National Association of Broadcasters Television Code has been amended to ban portrayal of doctors, dentists or nurses in TV advertising by other than members of those professions. Code is subscribed to by 308 stations and the three networks.

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PABLUM Cereals are the original pre-cooked cereals for babies. Vitamin and iron enriched. Pablum Mixed Cereal, Rice Cereal, Barley Cereal, High Protein Cereal, Oatmeal . . . *the* baby cereals made to pharmaceutical standards—especially processed for extra smoothness and lasting freshness.

BiB Juices are the newest addition to the Pablum Products family. The *first* medically accepted orange juice for babies is branded BiB. All five BiB Juices are processed to meet babies' special needs—Orange, Orange-Apricot, Prune-Orange, Pineapple with Acerola, and Apple with Acerola.

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You and Your Public . . .

Community Service Awards to Three Ohio Physicians Reflect High Honor on Them and Their Profession

WITHIN a 10-day period recently three Ohio physicians in three different communities were presented distinguished service awards by their fellow citizens.

Contrary to what some pollsters, surveys and self-appointed sages would have the public believe, the medical profession continues and will continue to enjoy high esteem. This is borne out by these awards, which mean good public relations for these three doctors and their profession.

Honors Deserved

These physicians didn't just happen to be selected for honors. Their honors came as the result of continued interest in and service to their communities.

In Middlefield, Dr. Hubert Shafer was honored as "Man of the Year" by the local Chamber of Commerce for his 31 years of service to his community.

In Bellefontaine, Dr. A. J. McCracken was presented with the Bellefontaine Kiwanis Club's Distinguished Service Award. Dr. McCracken enjoys a long history of community service.

In Garfield Heights, Dr. Charles Blaugrund was named "Man of the Year" by John R. Lawrence Post 304, American Legion. This recognition also resulted from a record of outstanding civic service on the part of Dr. Blaugrund.

It should be noted that these physicians achieved such recognition for their contributions primarily to the medical life of their communities, in addition to contributing to other aspects of community life. It is good public relations for the physician to give his best professional interest and service to his community.

Not Done Just For PR

This is not meant to say that such should be done only for the sake of public relations. It should be done for the sake of good medicine, and the result is worthwhile PR. Public Relations is not press agentry. Public relations has been defined by experts in the field as "doing a job well, and getting credit for it." It is not something artificial.

Thus, these physicians have been "doing a job well" and their fellow citizens have seen that they got credit for it. There is nothing artificial about their accomplishments.

This presents medicine and the medical man in the best possible light. It is far more penetrating, productive and lasting than a mass approach to medicine's PR problems.

American Association of Medical Assistants Meeting Announced

Plans have been made for the Second Annual Convention of the American Association of Medical Assistants at the Palmer House, Chicago, October 31, November 1 and 2.

The American Association of Medical Assistants is made up of those employed as assistants in the offices of doctors of medicine. The Association was conceived in Kansas City, Kansas, during the fall of 1955 when interested persons from 15 states met to make plans for a formal organization. The second meeting was held the following year in Milwaukee, Wisconsin, at which time a Constitution and Bylaws were adopted and the Association formally set up. During this first official year, a great deal of work was done and the First Annual Convention was held in San Francisco, California, in October, 1957. Now, it has a membership of nearly 6,000 representing 17 states and has the approval of the American Medical Association. The Ohio Society of Medical Assistants was approved recently by the Ohio State Medical Association's Council.

The purposes of the Association are stated as follows: To inspire its members to render honest, loyal and more efficient service to the profession and to the public which they serve; to strive at all times to cooperate with the medical profession in improving public relations; to render educational services for the self-improvement of its members; to stimulate a feeling of fellowship and cooperation among the societies.

Several states now offer fine educational courses with the cooperation of their colleges and universities which will help the assistant to become more valuable in the doctor's office. The American Association plans to offer courses on a national level as soon as a suitable curriculum has been set up.

Comments by investigators on

Robaxin®

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Robins

—the remarkably efficient skeletal muscle relaxant, unique in chemical formulation, and outstanding for sustained action and relative freedom from adverse side effects.

PUBLISHED REFERENCES: 1. Carpenter, E. B.: Southern Medical Journal 51:627, 1958. 2. Forsyth, H. F.: J.A.M.A. 167:163, 1958. 3. Little, J. M., and Truitt, E. B., Jr.: J. Pharm. & Exper. Therap. 119:161, 1957. 4. Morgan, A. M., Truitt, E. B., Jr., and Little, J. M.: J. Am. Pharm. Assn., Sci. Ed. 46:374, 1957. 5. O'Doherty, D. S., and Shields, C. D.: J.A.M.A. 167:160, 1958. 6. Park, H. W.: J.A.M.A. 167:168, 1958. 7. Truitt, E. B., Jr., and Patterson, R. B., Proc. Soc. Exper. Bio. & Med. 95:422, 1957. 8. Truitt, E. B., Jr., Patterson, R. B., Morgan, A. M., and Little, J. M.: J. Pharm. & Exper. Therap. 119:189, 1957.

Supply: Tablets (white, scored), 0.5 Gm., bottles of 50 and 500.

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Summary of four new published clinical studies:

Robaxin Beneficial in 95.6% of Cases of Acute Skeletal Muscle Spasm[1, 2, 5, 6]

CONDITION	NO. PATIENTS	RESPONSE			
STUDY 1[1]		"marked"	moderate	slight	none
Skeletal muscle spasm secondary to acute trauma	33	26	6	1	—
STUDY 2[2]		"pronounced"			
Herniated disc	39	25	13	—	1
Ligamentous strains	8	4	4	—	—
Torticollis	3	3	—	—	—
Whiplash injury	3	2	1	—	—
Contusions, fractures, and muscle soreness due to accidents	5	3	2	—	—
STUDY 3[5]		"excellent"			
Herniated disc	8	6	2	—	—
Acute fibromyositis	8	8	—	—	—
Torticollis	1	—	—	1	—
STUDY 4[6]		"significant"			
Pyramidal tract and acute myalgic disorders	30	27	—	2	1
TOTALS	138	104 (75.3%)	28 (20.3%)	4	2

THE JOURNAL of the American Medical Association

"In the author's clinical experience, methocarbamol has afforded greater relief of muscle spasm and pain for a longer period of time without undesirable side effects or toxic reactions than any other commonly used relaxants . . ."[2]

THE JOURNAL of the American Medical Association

"An excellent result, following methocarbamol administration, was obtained in all patients with acute skeletal muscle spasm."[5]

THE JOURNAL of the American Medical Association

"In no instance was there any significant reduction in voluntary strength or intensity of simple reflexes."[6]

Southern Medical Journal

"This study has demonstrated that methocarbamol (Robaxin) is a superior skeletal muscle relaxant in acute orthopedic conditions."[1]

You and Your AMA

Some Highlights and Sidelights on the American Medical Association's Activities and Program

"Widescreen medical public relations" focusing on a broader segment of national life will be considered when key medical men meet in Chicago August 27 and 28 for AMA's 1958 PR Institute. The 1958 session at the Drake Hotel, billed as the "V.I.P. Meeting," is designed for physicians, medical society staff personnel and others working in the medical public relations field. The keys to the medical profession's public relations program in the year ahead are symbolized in the meeting title and will be revealed at the day-and-a-half-long session.

The workshop-styled program will get down to PR practicalities at its opening session with a discussion of medicine in a changing world. From the lead-off "what do you know?" session the meeting will move into deliberations on "what have you got to say?" "how do you say it?" "whom do you know?" and "are they listening?"

Top people in related fields, including communications and human relations, will take part in the program.

Report on Hill-Burton

Results of a two-year study of the Hill-Burton Hospital Survey and Construction Program will be available in booklet form soon from the Committee on Medical and Related Facilities of the AMA's Council on Medical Service. Sections included in the report—introduction; summary; conclusions; recommendations; federal grants-in-aid; background and basic administration; general hospitals; tuberculosis hospitals; public health centers; mental, chronic disease and nursing home facilities; diagnostic or treatment centers; rehabilitation facilities, and other reference material. In addition to reviewing the legislative background of the Act and a voluminous amount of other data, reports on field surveys made in the following states are included: Arkansas, California, Connecticut, Georgia, Illinois, Iowa, Kentucky, Maryland, Michigan, Mississippi, Montana, New Jersey, Oregon and Washington. A limited number of copies will be available to individual physicians and medical societies.

Nursing Home Study

A field survey of approximately 25 skilled nursing homes in various sections of the country is being conducted this summer by the AMA's Council on Medical Service. Primary purpose of visits to these public, proprietary and non-profit facilities will be to obtain data that will aid in developing recommended guides and standards governing medical care in nursing homes. It is expected that much valuable information will be gathered on other important phases of nursing home operation—including nursing care, social service, food service, staffing and personnel policies, and costs. Tentative plans call for publishing the results of the survey, along with suggested standards for medical care and supervision, this fall.

This field study is one of the activities which has grown out of meetings of the liaison committee of the American Medical Association and the American Nursing Home Association. Other problems currently under the committee's consideration are the adequacy of welfare payments for nursing home care, ways of financing new and improved nursing home facilities, and stimulation of a better working relationship between nursing homes and physicians at both the state and local levels.

New Film on Food Quackery

How modern "medicine men" dupe the public into spending millions of dollars on unnecessary or over-priced nutritional products is the story unfolded in a new American Medical Association film. Prepared especially for airing over local television stations under the auspices of local medical societies, this new 27-minute film—"The Medicine Man"—dramatically pinpoints the fight against quackery in the food and nutrition field.

The film singles out problems which stem from health lecturers who travel from town to town giving misinformation on nutrition as a tie-in to plugging their products of questionable merit and from door-to-door salesmen who misrepresent the value of nutritional products. The film also shows how the medical profession cooperates with the Food and Drug Administration and voluntary agencies such as the National Better Business Bureau in the crackdown on these food quacks.

First showing of the film will be at the AMA's Public Relations Institute August 27-28 at the Drake Hotel, Chicago. Prints will be available to local medical societies after September 15 from the AMA TV Film Library.

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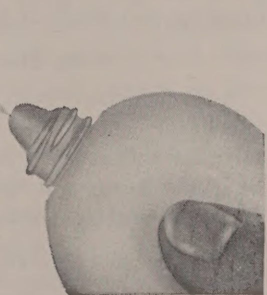

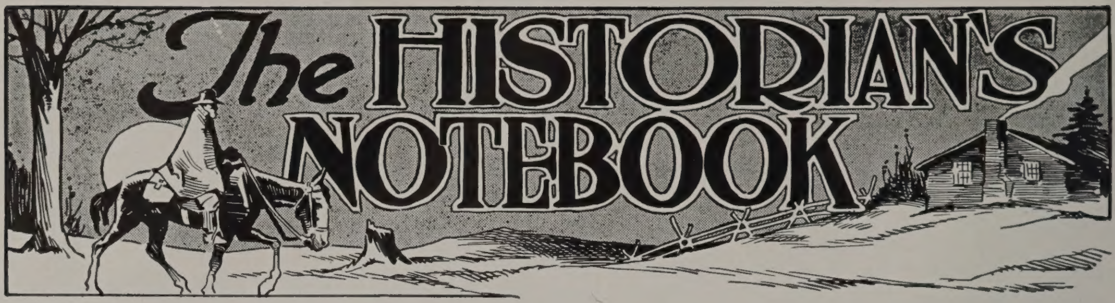

What of the Day, Sir?

MARTIN FISCHER, M.D.

HUNGER, pestilence, war and death remain the feared figures in the drama of mankind, and every generation has tried in its own way to mitigate the harshness of these monsters, both materially and spiritually. Success has varied.

Reliable geographic analysts inform us that 80 per cent of the world's peoples stand chronically on the verge of starvation—due either to lack of quantity or of quality of food. We remain entangled in the laws of Malthus, who a century and a half ago pointed out that as food supply doubles, population number, trebles. Because for us this situation lies far in the future, and because faithful missionaries have carried our surpluses to every needy portion of the globe, we incline to forget it all and to do nothing adequate to stop an ascending spiral.

The hopefuls believe that having struggled out of some short-lived disasters, we will always be able so to do. But is that true? It brings up the difficult chapter of raising more food and/or of engaging in birth control. New lands will be found and better fertilizers will be discovered (or be produced artificially) but, obviously, these schemes will only ameliorate, not abolish, an economico-biological law. (And the Government will be of little help when at the same time it subsidizes the one farmer for keeping land out of production, even as it subsidizes a second for bringing arid lands in.)

Why More People?

Any discussion, even, of birth control arouses violent objection. The military has always been for more soldiers; the farmer desires sons to continue the farm; and the industrialist likes large pools of workers—both male and female. Until recently the wardens of our morality have rid themselves of the load by labelling the whole idea of family limitation, sin.

The Author

● Dr. Fischer, Cincinnati, is emeritus professor of physiology, University of Cincinnati College of Medicine.

What now gives concern in school, court and playground is not only the numerical increase but the inequality of the starting material. As everybody knows, men are not born equal, and to be good for society it is the better-endowed—morally, mentally and physically—that we would have decorate our stage. We prate much about how these inborn inequalities may be corrected toward better side.

The Communistic Approach

One group holds that the distribution of food and of goods is poor; and that with proper consideration of the environment in which man lives, all might be fed both in their bodies and in their souls. But the history of new-dealism, socialism and communism does not in practice support these philosophies. Recall that colonies, like those of Jamestown and Plymouth, all failed as long as they lived together on a communistic basis. Not until the Plymouth Colony had returned to a free enterprise system—and that was three years after their landing—was there enough overproduction to permit the inauguration of a day of feasting and thanksgiving. After these, consider the economic tragedy of Friendship in Maine, of Robert Owen's community in Indiana, of Ohio's settlement in Lebanon, of Kentucky's Shakertown

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Read before The Literary Club, Cincinnati, Ohio, January 27, 1958.

below Lexington. It took a little longer for them to die, but die they did!

The Medical Approach

Better progress toward the longer and happier life is registered in the increasing conquest of pestilence. It took only a half century to increase man's life span in the United States from less than 50 years to over 70. Compare this with the twenty-odd years of life allotted to the Asians and the southern-lying hemispheres. U. S. A.'s feat was accomplished by a better appreciation of what are the sciences of agriculture and animal husbandry, aided and abetted by the great advances in bacteriology and hygiene.

The middle thirties of this century brought glad hosannas when it was found that, employed early, the sulfonamides and the antibiotics could forestall many a major operation. The latter cut down enormously, morbidity; and in best case, cut it out. This is because most disease is a battle between a parasite and a host; and the modern drugs turn the tide in man's favor. An earache was not so often followed by a purulent mastoid bone; not every appendix exploded; and not every abscessing Fallopian tube called for excision. The last item was important because in this surgery, excision of the ovary, too, was often required. The modern drugs saved the woman a spaying—and all its bitter emotional aftereffects.

And now about another hush-hush story!

The Biologics of Sin

The modern radio songstress bids you "take a chance!" Employed in a business sense, this might refer to the romance of business risk. But more sentimentally viewed, it refers to the romance of "the night before." Regarding it, one school of thinkers would escape the discomforts of brain work by simply ignoring the question of sex. But that is not easy, for sex is one of the only three instincts by which all life maintains itself. As of now and in the future, dalliance will be a less romantic but a safer affair. It will allow sin to grow because its accompanying dangers are being increasingly eliminated. And how? By the simple trick of soaking the principals concerned, prophylactically in the antibiotics. Thus will chemistry make meaningless the dogma that the sins of the fathers will be visited upon the children.

Confusion

Like the rest of the world, the war situation and the desire of man to be free befuddle me. A cartoon by Alan Dunn in a recent *New Yorker* (July 27, 1957) gives me solace. Two construction workers, 10 stories above the street level, are guiding an "I" beam into place. One speaks to the other: "I figure, what's it matter? If cigarettes don't get you, the fall-out will!" For the truth, keep listening.

Some years ago I ventured the opinion that there would never be a third world war in which gas would be employed. It was for a very simple reason—military victory has become as destructive of the conqueror as it is of the other fellow. Fight continues, as Lord Russell has phrased it, only as long as you believe that your enemy is suffering more than you. To rule a land requires occupation, and ground poisoned for the conquered, is poisoned for the invader also.

Substitute in the arms race, the atomic missile for poison gas, and you have the situation as of today, the facts of which are only slowly coming in. The public has thus been permitted to observe that the first atomic bomb was dropped on Hiroshima on August 6, 1945. Out of a population (in round numbers) of 344,000, the dead were 78,000, the injured 37,000 and the missing 13,000. The casualties, in other words, were one third of the population. When a second bomb was dropped on Nagasaki, similar figures appeared. Out of Nagasaki's population of 250,000, the dead alone were 73,000—again nearly one-third!

Ways to Death Compared

But this recitation does not tell the complete story. It is not these immediate effects of the bomb that need trouble you, but the remote. Shock and light only tear to bits and burn and fry you if within a radius of several miles; it is the fall-out that writes a story that is forever.

In simplest terms it is the x-ray-like emissions that sooner or later maim and kill; and in a most ugly manner.

The radiations from an atomic bomb are more and denser than those of the x-ray tubes employed in medicine. But in nowise are they different. In fact, clinical experience has been a sort of laboratory for the testing of radiation effects. It has become common knowledge that the x-ray specialists live five years less than the professional average, and that in the years of their work they develop anemias, leukemias and cancer. As for the overdosed patient, so for the victim of the atomic bomb—his state is the same but intensified.

There occurs in the acute case what is called radiation sickness and the stricken may in weeks vomit himself to death. But it may be a decade or two before the aftereffects manifest themselves—

and most subtly. The fine mechanisms of cellular growth are disturbed, distortion results and a "mutant" of questionable value is born.

Where Are You Going?

Now just a line on what Civil Defense may accomplish. The answer is, *nothing!* As the genius-builder of the highways and the parkways of New York, Robert Moses, has pointed out, the entire plan of creating a civil defense to duplicate what we already have in the Government, has proved a fiasco. The already overcrowded roads will not widen for a fleeing multitude, and those on the run will not know in which direction to go.

Some months ago, a colleague of mine passed the signboard before a public school. It read: "In case of attack, use this building as a shelter." He took some chalk from his pocket and relettered the sign: "In case of attack, this shelter won't be here."

But if there is no refuge upon the earth, neither is there one below, for the very design of a bomb cellar to avoid disaster is one that will better invite it. The ventilating system called for, will only bring the atomic dust of the atmosphere more quickly into the shelter, to create a situation that will come about anyway. Can nothing be done? The plan of a patient of mine is good. She is going to seek out a corner in the region in which she may be, and pray.

When is Life Long?

The fourth rider of the Apocalypse is death. Can it be outwitted, and for how long?

In the centuries gone, man has established himself as the ruler of the earth. He has accomplished this because he has multiplied and because with time he has learned the better way in which to down his enemies beginning with those of the beasts of the field and ending with the viruses. Thus he has more and more deferred the hour of his death. Instead of needing to meet death in his twenties, he could with better knowledge, wait into his forties.

But man did not stop there. Today he can sit secure (in U. S. A.) into his seventies. Will he endure to his biologically calculated age at death of 140? Nothing stands against that possibility, wherefore it may be asked how long *can* he live, or in reverse, why death at all?

Up to a short time ago, the oldest living thing in our world was the redwood of California. It was calculated that it and the Christian Era got started at about the same time. But now the botanists have come forward with a new finding—that of a Pacific Coast pine at least 3,000 to 5,000 years old!

Just how long is eternity?

Of Historical Interest

From the Closed World to the Infinite Universe, by Alexandre Koyre. ($5.00, *Johns Hopkins Press, Baltimore 18, Md.)* This is one of the Hideyo Noguchi Lectures in which this famous historian of science charts the path beginning with the philosophy and science of the Middle Ages and changes in thinking and appreciation of the 16th and 17th centuries which changed things into the world of the modern with its concept of an infinite universe and devoid of all hierarchial structure. It begins with Nicholas of Cusa, goes on to the works of Copernicus, Bruno, Kepler, Descartes, Newton, and Leibniz and the other thinkers of the period. Particular attention is given to the 17th century discussion between Descartes and Henry More and to the world view of Newton. Several chapters deal with the problems of the origin of the Newtonian conceptions and the reaction of Newton's contemporaries, such as Berkly, Raphson and Leibniz. Throughout the book the author keeps close connection between the development of scientific and philosophical thoughts and their interreactions.

The Road to Inner Freedom: The Ethics, by Baruch Spinoza. ($3.00, *Philosophical Library, New York 16, N. Y.)* Edited and with Introduction by D. D. Runes. **Ethics,** by Spinoza, is well known to professional philosophers. However, it has never received the wide reading that it deserves. For this the editor offers a very simple reason. Although dealing with the problems of man's emotional and intellectual life in direct and forthright terms, Spinoza saw fit to couch his ideas in mathematical formulations and scholastic terminology. Because of danger to himself and family because of religionists he never dared print the text during his lifetime but the book was circulated widely in manuscript form. It became familiar to most of the intellectual leaders in western Europe in the 17th century. Even this limited circulation brought the author into conflict not only with the Jewish religious bodies of Amsterdam but with the representatives of the various Christian churches.

The Cultural Life of the American Colonies, by Louis B. Wright. ($5.00. *Harper and Brothers, New York 16, N. Y.)* It covers the period from 1607 to 1763. Since it reports on the cultural interest and achievement of our Colonial ancestors, in terms of their opportunity, their social status, their national origins and geography, it fills a very useful niche in the library of those of us who are interested in the background of American scientific knowledge.

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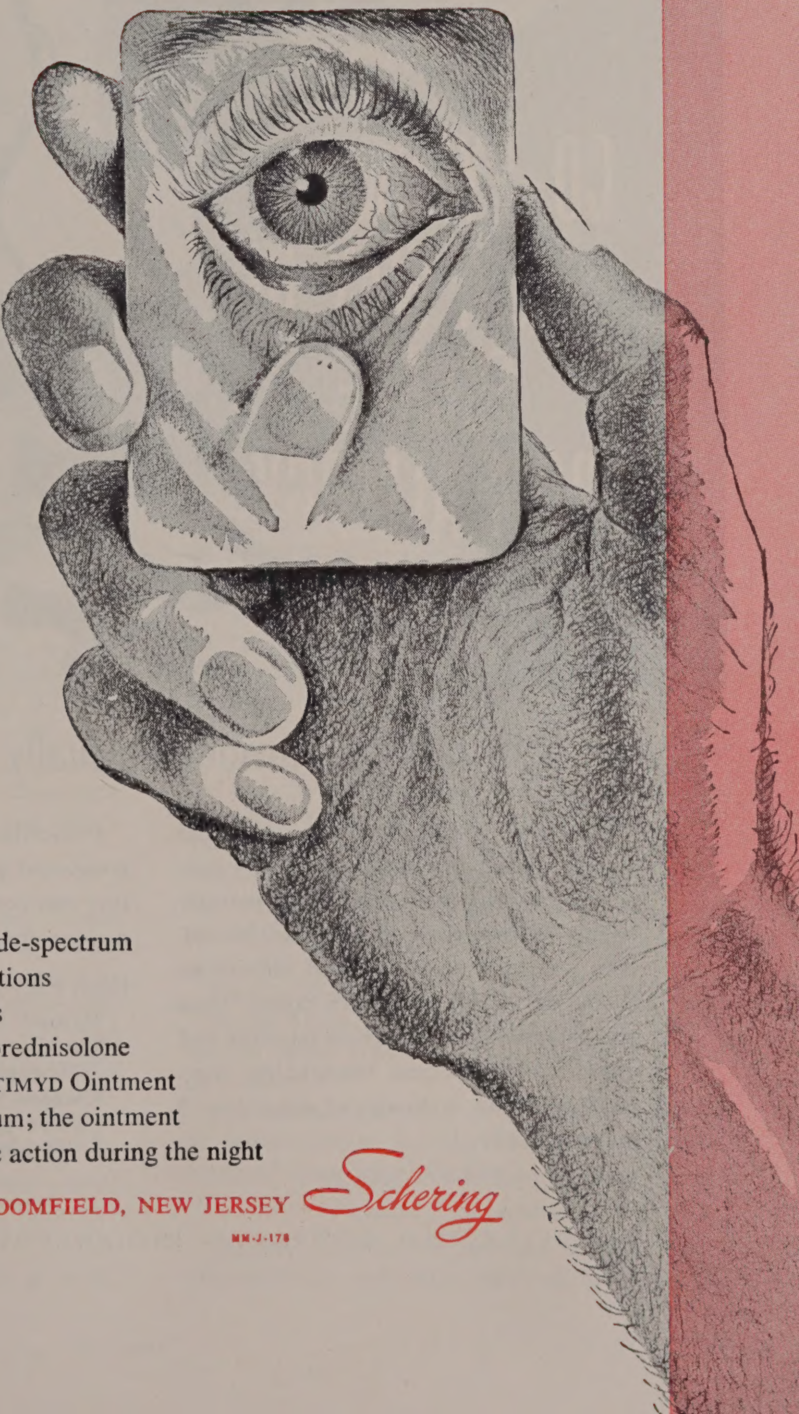

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Survival Following Rupture of an Arteriosclerotic Abdominal Aortic Aneurysm (Report of a Case)

JACK E. TETIRICK, M.D.

RUPTURE of an abdominal arteriosclerotic aortic aneurysm need not lead to immediate death from exsanguinating hemorrhage. Appreciation of the fact that there is usually a period of time in which typical symptoms may be recognized prior to the final episode of rupture into the free peritoneal cavity or into a viscus can yield an appreciable salvage of such patients. Even after the rupture into the free peritoneal cavity has occurred there can be opportunity for survival providing immediate surgical therapy is instituted.

The surgical undertaking is one of precision and magnitude in terms of facilities, personnel, and the care of expected complications. In view of an increasing distribution of the facilities for aortic replacement, a careful chronologic description of an actual incident may help those who desire to be prepared to meet this urgent surgical emergency.

The Author

● **Dr. Tetirick, Columbus, is a member of the attending staff, University Hospital, and instructor in Surgery, The Ohio State University College of Medicine.**

Case Report

History of the Present Illness. Mr. — was admitted for the first time to the Emergency Ward of the Massachusetts General Hospital on June 13, 1956. The patient was a 72 year old watchman who complained of abdominal pain and vomiting of two days' duration. For approximately one year he had been complaining of vague abdominal pain described as a "bloating feeling" associated with moderate anorexia. During the four to five weeks prior to admission the patient had felt that there was an objective and subjective increase in the size of his abdomen.

Two days prior to admission, while at work, he was seized with a severe pain which was described as being predominately in the right upper quadrant of his abdomen, and radiating occasinoally to the right lower chest. About one hour after the pain commenced, the patient vomited for the first time and thereafter was unable to retain any food up to the time of admission. About one hour before being admitted to the Emergency Ward he was reported to have been unresponsive, cold, and clammy. It was stated that just prior to his admission he had passed three small black stools. The patient denied any hematemesis or melena other than the above history. He denied any recent change in bowel habits. The patient stated that he had lost approximately 45 pounds in the year prior to admission.

Family History. Noncontributory.

Social History. Noncontributory. He smokes two to three cigars per day. Alcoholic intake was denied.

System Review. The only pertinent finding by system review was the finding of a chronic cough of many years' duration.

Physical Examination

Physical examination showed a thin, pale, chronically ill male who appeared to be of his stated age. A somewhat uriniferous odor was noted to his breath. The blood pressure was 88/50. Pulse 90. Respirations 16. Temperature 98°.

Skin and Lymph Nodes. Negative.

EENT. Examination of the eye ground showed 2 to 3 plus arteriosclerotic changes with some arteriovenous nicking, otherwise this portion of the examination was negative.

Heart and Lungs. Examination of the lungs by percussion revealed bilateral dullness in the bases posteriorly and by auscultation there was diminished breath sounds and fine to medium rales extending one third of the way upward from the base. The heart was enlarged to three centimeters beyond the left mid-clavicular line. There was a grade 2 basal systolic murmur. This murmur was widely transmitted. The cardiac rhythm was regular.

Abdomen. Examination of the abdomen revealed it to be protuberant and distended with dullness posteriorly in the flanks and tympany anteriorly. There was no shifting dullness or definite fluid wave. The abdomen was too tense to feel any organs or masses. The genitalia were normal.

Rectal. Rectal examination showed an enlarged prostate gland which was smooth and symmetrical.

Extremities. Examination of the extremities showed bilateral posterior tibial pulsations. There was no clubbing or edema.

Neurological Examination. Noncontributory.

Laboratory Data

On admission the patient had an hematocrit of 21 per cent. The hemoglobin was 5.8 Gm. per 100 ml. The white blood cell count was 11,150. The differential was as follows: polymorphonuclear leukocytes 81, lymphocytes 17, monocytes 2. The red blood cell morphology showed hypochromic cells with a moderate anisocytosis and microcytosis. The reticulocyte count was .2 per cent. A bone marrow study was reported as entirely normal. The platelets were normal in number and appearance. The serum sodium was 132 mEq./l, the serum potassium 3.9 mEq./l, the serum chloride 96 mEq./l, the CO_2 was 29 mEq./l; the blood *p*H was 7.45, the nonprotein nitrogen 62 mg. per 100 ml; creatine was 2.74 mg., and the serum water was 279 milliosmols/l; the serum iron was 70 micrograms (normal 50-200). Three guaiac determinations were done on the stool for occult blood and all were negative. A blood Hinton test was negative.

An electrocradiogram showed normal sinus rhythm and was considered normal except for several minor T wave abnormalities. An x-ray film of the chest showed some atelectasis of the left lower lobe. An x-ray film of the abdomen showed moderate gas and fecal material scattered throughout the colon. There were some irregularly shaped calcifications arranged roughly in the form of an arc just to the right side of the second and third lumbar vertebrae and they were thought likely to lie in the wall of an aortic aneurysm.

The cardiac compensation was thought to be borderline with a venous pressure of 175 mm. of saline and a circulation time of 20 seconds.

Hospital Course

For the first two days of the hospitalization the patient continued to complain of moderate abdominal pain and it was during this time that most of the foregoing laboratory and diagnostic data were obtained. On the afternoon of the third hospital day, while visiting with relatives, the patient suddenly became unresponsive and went into profound shock with an unobtainable blood pressure and pulse. The abdomen immediately became very tender and all bowel sounds disappeared.

At that time he was seen in consultation by the author at the request of the medical service. The opinion expressed at that time was that the history was most consistent with a neoplasm of the colon which had perforated. Note was made of the fleck of calcium on the abdominal film and it was suggested that an aneurysm which had ruptured was a definite diagnostic possibility. Early exploration was recommended and accepted by the patient's physician and family. Immediate massive blood replacement was begun and the patient was transferred to the operating room.

Operative Report

Preoperative diagnosis: Perforated carcinoma of the colon. *Postoperative diagnosis:* Ruptured aortic aneurysm. *Name of procedure:* Resection of abdominal aortic aneurysm with homograft.

Under satisfactory nitrous oxide-anectine-cyclopropane anesthesia, the patient was placed on the operating table in a supine position. The abdomen was prepared with soap, alcohol, and Zephiran® solutions. Sterile drapes were applied and the abdomen was entered through a long left perimedian incision. Upon opening the abdomen, fresh arterial blood was encountered in profuse quantities; the small bowel mesentery was filled with clots and there was a huge retroperitoneal hematoma. Therefore, the incision was extended upward and downward until it ran from the pubis to the costal arch.

Control of the aorta superiorly was secured by passing a shoe string behind it and attaching this to an occlusive clamp which was the Linton modification of a Bethune lung tourniquet. This clamp was then closed so as to occlude the aorta above the renal arteries and thereafter the clot was rapidly extracted and the aneurysm exposed. Bulldog clamps were placed across the iliac vessels. The aneurysm was then resected on the free surface, but a portion of the aneurysm wall was left in situ on the caval and posterior side. When the upper end of the aneurysm had been dissected and divided, the proximal end of the aorta below the renal vessels was controlled with a Crafoord clamp and the Bethune tourniquet was released allowing perfusion of the kidneys with arterial blood. The period of absolute renal ischemia was 27 minutes.

Following this, an aortic frozen-irradiated homograft was placed in the defect. An en-to-end suture technique was used at the upper end utilizing a vertical mattress suture of 5-0 arterial silk. On the anterior portion of the graft it was necessary to make a small vertical incision in order to enlarge the orifice of the graft to make it more nearly correspond to the aortic lumen of the host. On the inferior end, an end-to-side technique was used to anastomose the graft to the common iliac vessels. There was good retrograde blood flow when these vessels were opened. The ends of the vessels were sutured using an over and over suture of 5-0 arterial silk.

After the left anastomosis had been completed the clamps were removed and the blood was allowed to flow through the graft and down the left leg. The suture lines were hemostatic. The right anastomosis was made and the clamp was taken off the limb of the graft following which more adequate hemostasis was secured. As much clot was then removed from the retroperitoneal area as possible and the parietal peritoneum was closed to the small bowel mesentery in the region of the dissection with a running 2-0 chromic catgut suture.

The anterior peritoneum was then closed using a running suture of 0 chromic catgut. Through and through wire sutures were placed through the external rectus fascia. The fascia itself was closed with interrupted sutures of 3-0 silk. The through and through sutures were tied and the skin was closed with interrupted sutures of 5-0 silk. Upon completion of the procedure the patient had received 13 blood transfusions. There were palpable bilateral dorsalis pedis pulses. The patient's condition was recorded as fair.

Postoperative Course. The postoperative course was stormy. He developed a profound ileus and had considerable difficulty with tracheobronchial secretions. On the second postoperative day a tracheostomy was performed. The urine output remained low and on the fifth postoperative day the patient was noted to be jaundiced. The jaundice was thought to be the result of an incompatible blood transfusion although no gross reaction with any of his 21 transfusions had been noted (4 preoperative transfusions, 13 operative transfusions, and 4 postoperative transfusions).

Although his urine output remained low the patient's nonprotein nitrogen remained in the range of 45 mg. The study of the electrolytes and other blood chemistries revealed only a moderately elevated carbon dioxide content. This elevation was thought to be related to his respiratory problem, and following the tracheostomy and clearing of the pulmonary sepsis the CO_2 content returned to levels approaching 30 mEq./l. An arterial oxygen saturation was performed on the fifth postoperative day and showed 81 per cent saturation.

The patient was disoriented postoperatively and very difficult to manage, but this gradually cleared and by the twelfth day his respiratory difficulty had subsided sufficiently to remove the tracheostomy tube. The jaundice lasted for two weeks. It reached a peak bilirubin of 7 mg. per 100 ml., and by the thirteenth postoperative day had dropped to 2 mg. After the jaundice, respiratory sepsis, and oliguria had cleared, the patient became well oriented, very active and alert, and resumed his former interest in baseball and life in general. All pulses remained palpable in the extremities. He was discharged to be followed in the outpatient department on the sixteenth postoperative day.

Follow-up Data. The patient was seen in the surgical outpatient clinic one month after the procedure and was found to be without symptoms. The incision was well healed. Two months postoperatively the patient returned to work and was completely asymptomatic. A follow-up letter was received from him on June 3, 1957 (one year following surgery) and is here quoted:

> "Dear Sir:
>
> "I have had no symptoms, complications or diseases since I was operated on last June 14. I have increased my weight from 104 pounds to 126 pounds.
>
> "My present condition is satisfactory and I feel real good.
>
> "Sincerely,
>
> "_______"

Discussion

Diagnostic Considerations. The sudden onset of abdominal symptoms in an elderly individual is likely to be due to a complication of vascular disease. When acute abdominal distress in such a patient is accompanied by anemia and episodes of hypotension in the absence of melena, the diagnosis of a ruptured abdominal aortic aneurysm should be considered as a leading possibility. Indeed, any elderly patient with vague and recurring abdominal pain should be considered for this diagnosis. Although the reports on this condition in the literature state that a pulsating abdominal mass is usually present, the exact status of the abdomen is very difficult to assess and it is unwise to attempt to delineate a mass by vigorous palpation or discard the diagnosis because such a mass is not present.[1,2,3.]

The presence of serious associated disease processes should not delay the decision to undertake an attempt of surgical correction of the lesion beyond the time needed to evaluate these processes for reference in the postoperative period.

Technical Considerations. A discussion of surgical technique is beyond the scope of this report. Several remarks, however, are pertinent to the problem of facing "profuse quantities of fresh arterial blood upon entering the abdomen." Application of direct pressure blindly among the coils of the bowel must be avoided as this will only serve to waste time and enlarge the aortic defect. The most rapid hemostasis is secured by direct aortic occlusion.

The surgeon should slide his hand up onto the liver and down on its ventral surface to the aorta just below the diaphragm. When the aorta has been reached in this area it is possible to insert the index finger behind it by direct blunt dissection thereby producing occlusion between the thumb and forefinger. The peritoneal incision and subsequent control of the iliac vessels is then performed by the surgical assistant. The aneurysm is then opened lengthwise to allow rapid evacuation of the clots and control of lumbar branches. The standard techniques for this surgery are then applicable.

Postoperative Care. The presence of a large amount of retroperitoneal blood and the stress of an episode of shock and a major surgical procedure frequently have a transient but severe effect on the mental status of an elderly patient. Disorientation and confusion may be expected. It is therefore mandatory that continuous observation of the patient be carried out by the nursing and resident staff to prevent the patient from harming himself, or interfering with the drainage tubes and other equipment.

The Levine tube should be left in the patient for five days. This will help avoid ileus with consequent respiratory and wound complications. It is not unusual to see ileus develop if the tube is removed early even though a moderate amount of peristalsis has returned by the third postoperative day.

The pulmonary reserve is limited in most of these patients due to age, pulmonary disease, high diaphragms, and a long painful abdominal incision. Useful measures include the use of high concentrations of oxygen, early tracheostomy, and by refusing to allow the patient to be restrained flat in bed for reasons of his mental status.

The precarious condition of renal function is best aided by rapid surgery with reduction to an absolute minimum of time during which the aorta is occluded above the renal arteries. In addition, the total operating time should be as short as possible. In this respect it is mandatory that the assistants to the surgeon and all categories of operating room personnel be well versed in the techniques of vascular surgery and that a second surgical team prepare the substitute vessel while the resection of the diseased segment is being performed. Further protection is afforded to the kidneys by adequate blood replacement, and it is essential that several units of blood be given rapidly as soon as the aortic occlusion is released with a return of flow to one or both lower extremities.

Summary and Conclusion

A case of an abdominal aortic aneurysm complicated by acute rupture is presented. Diagnostic and therapeutic principles are discussed.

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Adduction. The patient was contacted on July 10, 1958, and stated at that time he was asymptomatic and had had no difficulty with his legs or abdomen since his operation.

Permanently Incapacitating Knee Injuries

Ligamentous injuries to the knee are among the most common of the permanently incapacitating injuries received in football. The most often injured is the medial collateral and less often the cruciates and the lateral collateral. I have used the word *permanent* with regard to such incapacity because it is my belief that after repair of a collateral ligament the knee cannot endure the trauma one must expect in football.—James J. Daly, M. D., San Francisco: *California Med.*, 88:441, June, 1958.

Supine Hypotensive Syndrome in Pregnancy
(Report of a Case)

KEITH R. BRANDEBERRY, M.D.

THE sudden onset of hypotension during late pregnancy or during labor ordinarily suggests the occurrence of some severe and perhaps catastrophic complication. Prompt, and sometimes dramatic action is usually necessary to preserve the lives of the mother and the fetus. Nonetheless, acute hypotension occurring during these stages of pregnancy may be due to some benign disorder that does not demand such vigorous intervention. An example of such a disorder is presented in the following case report.

Case Report

Mrs. — was a 24 year old white primipara who entered Holzer Hospital on October 14, 1957, in early active labor. She had been followed through an uneventful prenatal course at this hospital. Her estimated date of confinement had been October 9, 1957. Her weight gain had been 29 pounds and blood pressure had ranged between 118/72 to 130/76. Urines were constantly negative. Laboratory work showed her to be Type A, Rh positive, hemoglobin 12.8 Gm., with a hematocrit of 41 per cent. The serologic test for syphilis was negative. Her only medication had been nutritive capsules, 1 three times daily. Her pelvic measurements had been noted to be small with the external conjugate 16 cm., the ischial spines 7.5 cm., and the true conjugate 11 cm. It was elected that she should have a trial of labor.

Upon admission at 6 p.m. October 14, her blood pressure was 122/82. She was having good contractions every four to five minutes. The cervix was 3 cm. dilated with membranes ruptured, vertex at minus 2 station. Throughout the night her contractions remained good and the cervix dilated to 9 cm. by 8 a.m., but without further descent of the vertex. Because of her failure to progress, it was elected to do a cesarean section. The patient was given Demerol®, 50 mg. and atropine, gr. 1/150 and sent to the operating room.

She was allowed to remain on the carrier outside the operating room in supine position for approximately 10 minutes, then moved onto the operating table. At this time, the anesthetists noted her blood pressure to be 30/0. The patient complained of feeling weak, but was not perspiring. Her pulse was barely perceptible. Meticulous examination, with the thought of a ruptured uterus, was negative except for the pulse and blood pressure noted. At this point, the patient was turned on her left side and within 20 seconds her pulse was good and the blood pressure was 112/64.

The Author

● Dr. Brandeberry, Gallipolis, is director of the Department of Obstetrics and Gynecology at Holzer Hospital.

She was then turned back to supine position and the pressure again became imperceptible. Upon returning the patient to her left side, the blood pressure was restored to normal levels. The abdomen was prepared with patient in this position and Sodium Pentothal® anesthesia induced. She was then quickly turned to supine position and usual laparotrachelotomy performed. This removal of the baby required approximately four minutes, and during the interval, the blood pressure again fell to unobtainable levels. As soon as the uterus was emptied, the pressure returned to normal and remained so.

The postpartum course was uneventful and the patient and her infant (weighing 7 pounds 7 ounces) were discharged on her sixth postoperative day.

Other Reported Cases

In 1951, McRoberts[1] first described this rather uncommon and interesting condition and presented six illustrative cases. He suggested that "in late pregnancy the uterus may obstruct the veins of the abdomen when the subject is in the strictly supine position, causing a rise in venous pressure caudally and a fall in pressure in the right auricle." De Regende[2] felt, "that the syndrome is dependent on a reflex produced by the stimulation of the nervous structures situated behind the uterus."

Howard, et al[3], reported two cases, one of which was subjected to cesarean section because of a suspected ruptured uterus. They felt that the condition was not clinically recognizable in labor because "during a labor contraction the uterus apparently 'rides' on the vertebral column and cannot exert pressure posteriorly on either side of the bony ridge." They were able to produce an acute hypotension in a near term bitch by ligation of the inferior vena cava below the level of the renal veins.

Conclusions

A case of Supine Hypotensive Syndrome during labor is reported. Our first thought, as has been the experience of others, was that of a ruptured uterus. By turning the patient on her side and observing the blood pressure rise, the proper diagnosis can be made promptly. This syndrome must be considered in any case of unexplained shock in late pregnancy. The ease with which the blood pressure could be made to rise or fall in the presently presented case suggests that McRobert's explanation of this phenomenon is the more accurate.

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Occurrence of Cross-Sensitization Between Related Compounds

A subject which requires some mention is that of cross - sensitization, or multiple sensitivities. These are not necessarily the same thing. Cross-sensitivity occurs between chemically related compounds such as paraphenylamine diamine, para-amino benzoic acid, para-amino salicylic acid, benzocaine, nupercaine and the sulfonamides.

Allergic sensitivity to one of these drugs may produce an allergic reaction on exposure to a second one of the group, without prior specific exposure to the second chemical, occurring before the eliciting exposure. It is true that people who form allergic reactions and have the capacity to do so may become allergic to more than one substance without the presence of true cross-sensitivity. This occurs not infrequently for the metals nickel and chrome. Oftentimes a person sensitive to nickel will also be sensitive to chrome.

Cross-sensitization occurs between poison ivy, poison oak, poison sumac, Japanese lacquer, mango and cashew nut shell oil. Cross-sensitization occurs between the oleo resins of the iris, from which the insecticide Pyrethreum is prepared, also ragweed and chrysanthemum. Tetramethyl thio-urium disulfide, the germicidal agent in a new soap, may cross-react with the thio-urium compounds present as antioxidents in some of the rubber articles, including some rubber gloves.—Charles W. Whitmore, M. D., Lynchburg, Va.: *West Virginia M. J.*, 54:238, July, 1958.

Fluro-Ethyl Cryotherapy

An Adjuvant in the Treatment of Acne Vulgaris and Postacne Scarring

By *Irving L. Schonberg, M. D.,** and
*Jerome Z. Litt, M. D.**

The use of refrigerants in the treatment of postacne scarring is well known, and, in a recent report,[1,2] J. M. Greenhouse discussed the use of liquid nitrogen in the treatment of facial scars. We have used liquid nitrogen in 56 cases of postacne scarring with very satisfactory results, and, in addition, have employed this same modality in 40 cases of "active" acne vulgaris, also with good results.

While using Fluro-Ethyl** as local anesthesia for the removal of superficial seborrheic keratoses and molluscum contagiosum lesions, a persistent erythema and desquamation of the peripheral zones of each of the treated lesions was noted. This observation suggested the use of Fluro-Ethyl refrigeration in the treatment of selected cases of "active" acne vulgaris and postacne scarring.

Method: The face is cleansed thoroughly with acetone and alcohol. The ears are plugged with pledgets of cotton and the eyes are shielded. The can of Fluro-Ethyl is held about four inches from the skin and the spray is then directed towards the affected region until the site becomes hard and frosted. This usually occurs at the end of three or four seconds, and, as the sprayed areas begin to thaw, adjacent sites are sprayed until the entire region has been treated. Erythema occurs almost immediately and persists for three or four days. Desquamation results in about 24 or 48 hours and usually persists for another day or two. Local desquamating preparations are avoided during this period, and the patient is re-treated every 14 days until desirable results are obtained.

Summary and Conclusions

We have employed Fluro-Ethyl as an adjuvant in the treatment of acne vulgaris and postacne scarring. The results, thus far, have been encouraging. The treatment is inexpensive and has the advantage of being readily available in all communities. It is very practical as an everyday office procedure.

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*Dr. Schonberg is co-chief, Department of Dermatology, and Dr. Litt, dermatologist, Outpatient Department, Mt. Sinai Hospital, Cleveland.

**A refrigerant containing 25 per cent ethyl chloride and 75 per cent dichlorotetrafluoroethane, and manufactured by The Gebauer Chemical Company, Cleveland 4, Ohio.

Diabetes

A Case Report on Preventable Blindness

WILLIAM H. HAVENER, M.D.

A BLIND EYE is a serious loss to both patient and community. Awareness of the preventable nature of a significant portion of this blindness should help in reducing the incidence of such tragedies. The representative cases to be presented here are selected to emphasize relatively common causes of blindness which can in many instances be averted by proper, timely care.

Case Report

This 75 year old white man was first known to have diabetes in 1949. Moderately severe diabetic retinopathy and early cataract were believed to be responsible for reduction of vision. Acuity was recorded as O. D. 20/100 and O. S. H. M. when he was first seen in the Ophthalmology Clinic in 1952. Tonometer tension was 38 O. D. and 70 O. S. (normal less than 27), indicating that unsuspected glaucoma had been responsible for his visual loss. The right visual field was constricted to one third of the normal size. His pressure has been controlled through surgery and miotics, and no further loss of vision has ensued during the past six years.

Discussion

Presence of typical microaneurysms (tiny red specks smaller than the caliber of an arteriole on the disc) or of neovascularization (arborizing capillary and venous channels) in the fundus will often permit the diagnosis of diabetes through ophthalmoscopy. Characteristically situated in the region of the macula, diabetic retinopathy may be responsible for severe visual loss. Complaints of poor vision from such a patient are often answered with the discouraging recommendation that he should accept his infirmity. Similar advice may be given the diabetic who is developing cataract.

The symptom of gradual, painless visual loss in late adult life certainly warrants careful ophthalmologic examination. Through history alone it may be impossible to differentiate between presbyopia, cataract, macular degeneration, diabetic retinopathy, optic atrophy, or chronic simple glaucoma. Indeed, just as in the case presented, several of these diseases may coexist. Suprisingly often a careful refraction will improve vision markedly over that obtained with the patient's old pair of glasses. Just as any other patient over 40 years of age, the diabetic has a 2 per cent chance of having glaucoma. Early detection and control would have prevented glaucomatous loss of vision in the case reported.

Unfortunately diabetic retinopathy may by itself cause blindness. The course of diabetic retinopathy is variable, with exacerbations and remissions, but severe cases gradually lose vision despite all therapy. Anticoagulants, vasodilators, vitamins, diet, insulin, and a multitude of other medications have been tried without convincing results. Probably the most practical approach is the statement that this eye trouble is only a symptom of a general disease, and that proper regulation of the diabetes and general health measures represents optimal care. Many physicians believe that careful control of the juvenile diabetic will result in significantly less retinopathy. This belief is open to the question whether poor control might represent more serious disease which would have been more likely to produce retinopathy anyway.

Rather sudden onset of blurred vision is commonly seen in a diabetic who is going out of control or is subject to insulin shock. Hydration and dehydration alterations in the lens cause these changes of focus. Refraction done during a period of poor control will often result in prescription of unsatisfactory glasses. It is wise to delay refraction until after several weeks of good regulation of the diabetes.

Spontaneous massive vitreous hemorrhage without a history of trauma is most often due to diabetes, hypertension, blood dyscrasia, or retinal detachment. Etiologic diagnosis is often impossible through examination of the involved eye, for the fundus cannot be visualized despite good dilatation of the pupil. Commonly similar changes will be present in the "good" eye, and will permit accurate diagnosis. This is one example of the application of the useful precept, "always examine *both* eyes, even though the patient may complain of only one."

The Author

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Antibody Identification in Blood Bank Service

C. R. MACPHERSON, M. D., and M. J. CHRISTIANSEN, M. T., A. S. C. P.

The Authors

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- **Miss Christiansen, Columbus, technologist in Clinical Laboratories, is Supervisor of Blood Bank, University Hospital.**

As the number of patients receiving blood transfusions increases, and more particularly, as the frequency of multiple transfusion increases, the problem of detection and identification of red cell antibodies becomes increasingly important. The *detection* of antibodies is of course the reason for the cross-match and is a process which is absolutely essential for any type of Blood Bank service. The *identification* of antibodies, although not of such obvious and immediate importance, is nevertheless an important aspect of Blood Bank function. This becomes more evident where the Blood Bank handles a large volume of blood and particularly where it serves a large obstetrical unit or a unit such as the Research Medicine Service of the University Hospital, Columbus, Ohio, where a high percentage of patients receive many transfusions over a long period.

Where antibody identification is not carried out, obtaining blood for patients who have antibodies depends upon a purely empirical process of cross-matching against a sufficiently large number of donor units until the desired quantity of compatible blood can be obtained. If the antibody is identified then a considerable saving of time and effort is effected, since it is much easier to type rather than cross-match a large number of bloods. This becomes even more obvious where the patient has devoloped several antibodies, as has happened in a considerable proportion of the cases reported here.

A natural development from the original Blood Bank functions is the detection of antibodies, particularly Rh antibodies during pregnancy. Where such antibodies are detected for the first time arrangements can be made to care for a possible erythroblastotic child. Detection and titration of antibodies during pregnancy is now a well established function of most Blood Banks.

Nature of Survey

The University Hospital Blood Bank has been systematically attempting to identify all antibodies encountered since April, 1957. This report covers the nine month period until December 31, 1957, during which about 11,000 transfusions were given. The technique employed is the use of a panel of eight cells, which have a known antigenic structure. These cells are supplied commercially by the Knickerbocker Foundation, of New York, under the trade-name "Panocell" and this organization has served as a reference laboratory to confirm, and in some cases extend, our findings, as has the Ortho organization, of Raritan, New Jersey.

The serum tested is, in effect, cross-matched against each of these eight cells and the reaction pattern obtained is compared with the table of antigenic structure supplied with the cells. In most cases the antibody can be readily identified but in some cases further study with specific cell types is necessary. Table No. 1 lists the antibodies found, and shows the service on which the patient was admitted. Table No. 2 shows the distribution of patients possessing multiple antibodies. Several of these antibodies are worthy of further comment.

One anti-M antibody was found in a woman whom we believe to have had an erythroblastotic child. This is the third known instance in which

TABLE 1.—*Distribution by Clinical Services of Antibodies Found*

Antigen Against Which Antibody is Directed	Total	Obstetrics	Research Medicine	Others
D (Rh_o)	30	25	3	2
C (Rh′)	7	2	4	1
E (Rh″)	3	1	1	1
c (Hr′)	1	1	0	0
e (Hr″)	0	0	0	0
V	1	0	0	1
M	2	1	0	1
N	0	0	0	0
Kell	4	0	1	3
Cellano	0	0	0	0
Duffy^a	2	1	0	1
Kidd^a	1	0	1	0
Lewis^a	2	2	0	0
O (H)	1	1	0	0
Total	54	34	10	10

TABLE 2.—*Patients with Multiple Antibodies*

Case No.	Sex	Age	Blood Type	Service	Antigens Against Which Antibodies Found	Comment
1	F.	25	O. Neg.	Prenatal	D (Rh_o) & C (Rh′)	1 abortion, 6 pregnancies. Last child severely affected.
2	F.			Prenatal	D (Rh_o) & C (Rh′)	No information—specimen by mail.
3	F.	22	A neg.	Gynecology	D (Rh_o), Duffy^a, O (H)	7 pregnancies, no transfusions No affected children.
4	M.	37	O neg.	Research Medicine	Kidd^a, Kell	Multiple transfusions for hemolytic anemia. One mild transfusion reaction.
5	F.	47	A pos.	Research Medicine & Isolation	D (Rh_o), C (Rh′), E (Rh″)	No pregnancies or incompatible transfusions, hemolytic anemia.
6	F.	47	O neg.	Surgery	D (Rh_o), C (Rh′), V	Known to have been given O positive blood in emergency.
7	F.	62	A pos.	Surgery	E (Rh″), Kell	10 pregnancies, 1 unit of blood.
8	M.	19	O neg.	Research Medicine	D (Rh_o), C (Rh′)	Christmas disease. O pos. blood given in 1950. Titer maintained since.
9	F.	46	O pos.	Gynecology	E (Rh″), c(Hr′)	2 pregnancies, 1 abortion, 1 unit of blood 1955, 1 unit 1957, then developed antibodies.

this has occurred and will be reported more fully elsewhere.

One example of anti-Lewis^a came from a woman who had nine pregnancies and multiple transfusions and there is no way of telling which of these factors was responsible.

The anti-V antibody came from a Mexican woman who had had multiple transfusions. Only one of these, about three weeks prior to the discovery of the anti-V, was from a Negro donor. This antigen is almost confined to the Negro race and the association of anti-V with anti-C is very common. This particular anti-V is apparently the first example of such an antibody which is active in saline medium.

In Case No. 5, (Table 2), the patient who possesses anti-D, anti-C and anti-E, also possesses these factors on her red cells. She suffered from an acquired hemolytic anemia and a complete clinical remission was caused by splenectomy, although the immunological process still persists. This patient was originally reported to have anti-D and anti-E (Crowley and Bouroncle, 1956), but developed anti-C as well during a subsequent hospital admission. This case will be reported in more detail elsewhere.

Comparison of tables 1 and 2 will show that although the majority of all the antibodies detected have come from patients on the obstetrical service, a much smaller proportion of patients with multiple antibodies came from this service. This finding confirms the observations of others that if patients receiving multiple transfusions are capable of forming antibodies, they frequently do so to more than one factor. Another aspect of this problem lies in the fact that women who are sensitized during pregnancy are exposed to the red cell antigens of the fetus only, whereas those sensitized by transfusion are necessarily exposed to a much wider range of antigens.

Summary

Antibodies encountered during a nine month period in a large hospital Blood Bank are briefly reviewed. Fifty-four antibodies were identified in the course of 11,000 transfusions, and 225 antibody titer determinations from the Prenatal Clinic.

The largest percentage of all antibodies were encountered on the obstetrical service. The majority of patients developing multiple antibodies did so as the result of repeated transfusions.

It is emphasized that identification of antibodies has a strictly practical application, as well as theoretical interest. When antibodies are identified the problem of finding compatible blood is made much easier.

Studies of the 1957 Influenza Outbreak in Indiana

An epidemic of A/Japan/305 influenza occurred in Indiana during the period of September 28, 1957 and December 14, 1957. Infection first occurred among teen-aged school groups and then spread to grade schools and finally adults. Influenza associated mortality was high in the age group under one year and in the age group over 60. Most frequent cause of death was pneumonia. Pre-epidemic levels of reported influenza were reached by the end of 1957.

Vaccine first became available in Indiana on September 5 when 26,736 cc.'s were received. By December 27, 1957, a total of 830,645 cc.'s of vaccine was made available in Indiana. Thus, it is apparent that vaccine became available in very limited quantities prior to the October increase and became more plentiful for the remainder of the year.—*J. Indiana M. A.,* 51:637, May, 1958.

Multiple Test Technique for Early Detection Of Cancer of the Cervix

RICHARD B. SALZER, M. D.

THE importance of detection and diagnosis of early carcinoma of the cervix uteri cannot be overemphasized. Carcinoma in situ can almost invariably be cured and the cure can be effected by relatively simple means. Considering even some of the very highest five year cure rates reported for invasive carcinoma the desirability of treating in situ carcinoma becomes really apparent.

Stage I	80 per cent
Stage II	60 per cent
Stage III	25 per cent
Stage IV	9 per cent

The type of treatment required to effect a cure adds even more weight to the importance of early diagnosis. The standard treatment of choice for carcinoma in situ is a total hysterectomy removing a wider than usual cuff of vagina. In the younger women the ovaries may justifiably be allowed to remain. Even conization with very careful follow-up may be sufficient therapy in the young women who desire more children. These variations in treatment are quite important since the average age at detection of carcinoma in situ is only about 36 years.

Then too, one cannot help but be impressed with low morbidity and mortality associated with total hysterectomy when compared with the serious and frequent complications and annoying after effects of either radical surgery or full irradiation treatment which is required for clinical invasive carcinoma.

There is growing evidence that the very early invasive carcinoma of the cervix, also termed preclinical invasive carcinoma and microinvasive carcinoma, is more closely allied to carcinoma in situ in regard to age incidence, cure rates, and type of therapy necessary than to carcinomas usually classified as Stage I (I. C.). By definition, however, these are actually Stage I lesions. These lesions can be found only by refined techniques of diagnosis but in large part can be diagnosed by methods which are available today. Philosophically, if there were some way to have all women report for frequent and thorough detection studies and if we, the doctors, would always perform all the indicated tests, invasive carcinoma of the cervix as we know it today could become a disease of the past.

Great steps can be made toward this goal if all women for whom pelvic examinations are performed would receive the benefit of a complete and systematic study of the cervix using all the available methods of early cancer detection. Fortunately the techniques which are available are painless, relatively inexpensive, and consume very little time.

The Author

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I will summarize some of the advantages and disadvantages of the various methods which should be used:

Biopsy

1. Biopsy is the last used but the most important of the methods. The biopsy with careful pathologic study is the only method by which a definite diagnosis of carcinoma can be reached. It is of necessity the last step in our study since all other techniques tell us only when, where, and how to perform the biopsy.

Random biopsies, especially multiple ones such as with the "four quadrant plan," whether the cervix appears normal or not, will detect a large percentage of early carcinomas. When, however, we consider the tremendous number of negative results which would ensue, we can appreciate the cost both in money and time for preparation and examination of the specimens. Then too, even with the taking of four, six, or eight punch biopsy specimens, areas of the remaining epithelium could harbor very small malignancies.

Indicated biopsy of any lesion grossly visible, results also in large numbers of negative reports. One again may geographically by-pass a malignant area while removing part of a benign lesion. Circular biopsy or sharp conization cannot be done on every patient whether a visible lesion is present or not, due to the required hospitalization, anesthesia, etc. It, of course, must be done when questionable results are obtained from punch biopsies or other diagnostic studies.

The Cytologic Smear

2. Development of the technique of cytologic examination of the smears from the cervical epithelium has made a tremendous change in our

thinking and practice pertaining to carcinoma of the cervix case-finding and too much praise for the help which the Papanicolaou smear provides cannot be given. Nevertheless, this tool does leave some things to be desired. If positive or questionable smears are obtained either in the presence or absence of grossly visible lesions, the same difficulties regarding site of biopsy are encountered.

At best, false negative results occur in about 10 per cent of cases later proven to have carcinoma. In personal communication with an excellent cytologist (Dr. James Rollins) who also practices colposcopy, I learned that his accuracy in cytologic diagnosis was greatly increased by taking extra time and care in screening the slides of cases which also had exhibited suspicious colposcopic findings.

Colposcopy

3. Colposcopy, by filling in information which is still missing after use of the other tests, is an extremely valuable tool in early carcinoma detection. Used alone it approaches cytologic diagnosis in accuracy but for the best advantage it is used in conjunction with the cytologic studies and other methods. The biggest disadvantage to colposcopy in this country at the present seems to be first, the lack of instruments and second, the paucity of trained colposcopists. Basic colposcopy is not too difficult to learn, but as with everything else in medicine, the value of colposcopic examination increases with the ability, training, and experience of the colposcopist.

By three dimensional visualization of the cervix through this binocular instrument under brilliant light a whole new world of cervical anatomy is encountered. Lesions too small to be seen by the naked eye are found and what grossly appears to be normal epithelium can be seen under the colposcope to be a hyperplastic type of epithelium. In larger areas of visible erosion one can differentiate distinctive small areas of which a biopsy is indicated if such be present. Many of the "erosions" which would have to be biopsied can be seen to be misplaced columnar epithelium, termed ectopy, or areas of admixture of non-hyperplastic columnar and squamous elements called transformation zone. Much else can be visualized with the colposcope but the scope of this paper does not permit its detailed description.

Generally, then, the colposcopic examination will not diagnose carcinoma but it will detect and differentiate from other lesions and normal epithelium, atypical and hyperplastic lesions of the exocervix and distal portions of the endocervical canal. These hyperplastic lesions represent anything from mild basal cell hyperplasia to invasive carcinoma and only tissue study will determine the degree of atypicality.

The Schiller Test

4. The Schiller test is a rather crude method of diagnosis since failure of cervical epithelium to stain deeply with an iodine containing solution indicates only abnormality and not type or character. Its only value when used in conjunction with these other tests is as a check on the human element of colposcopy. No information can be added to the colposcopic examination by the Schiller test but due to the vagaries of human perception the iodine staining of the cervix will show that no abnormal area has been overlooked during colposcopic examination.

Gross Visualization

5. Gross visualization is probably the least informative method for detection of the early carcinoma. Not only are the early lesions often too small or too indistinct to be picked up by this means, but also so-called "erosions" may be benign completely or have areas of malignancy within their confines. There is no way of suspecting which of these possibilities exist by gross examination. If none of the other methods is available or is used, biopsies should be taken of all "erosions." Again, the actual area of malignancy, if present, may be overlooked.

Summarization of Multiple Test Technique

In the way of summary then, the following is a list of steps which I suggest for early detection of carcinoma of the cervix:

1. Speculum is inserted and a quick visual survey of the cervix and vagina is made.
2. The cervix and vagina are examined colposcopically.
3. A cytologic smear is made containing material from the lower endocervix and the portio vaginalis using an Ayre spatula or similar instrument.
4. The cervix is wiped off with a sponge saturated with dilute acetic acid and colposcopy is repeated.
5. If squamous epithelium is seen to be growing up into the endocervical canal beyond visualization, a tiny curette is used to obtain endocervical tissue which is sent for histologic examination.
6. The cervix is stained with Schiller's solution and repeat colposcopic examination done if indicated.
7. Punch biopsy under colposcopic control is performed if indicated.

Using this multiple test technique I feel that early carcinoma of the cervix will be overlooked as close to "never" as is possible in medicine.

The Medical-Legal Relation of Injury To Spinal Arthritis

THEODORE A. WILLIS, M. D.

AN orthopedist who has not been subpoenaed as a witness in litigation involving injury and arthritis of the back may look forward to that experience with certainty. He may expect with equal assurance that in this event the plaintiff will endeavor to extract from him testimony in excess of the truth, while the defendant will attempt to suppress aspects of the truth unfavorable to his cause, the spoils of war in this parliamentary contest of wits being, not justice, but a court award which, whatever it may be, will be considered exorbitant from one viewpoint, inadequate from the other, in relation to the actual damage sustained by the victim of the accident.

The story, as so often told, is this: An individual is referred to a physician for examination and report concerning the degree of his disability and an estimate of the percentage of this attributable to an accident incurred two or three years previously.

According to the victim's statement, he had been in perfect health until he had strained, bumped or twisted his back in the course of his employment, or had been involved in an accident. Immediately, or perhaps within a day or two, pain had developed in his back. He reported the circumstances to his boss and was seen by his own, or the company doctor who diagnosed a sprain, contusion or lumbago, and advised rest, heat and aspirin. In a few days he was considered fit for work but still complained of pain with activity and refused to return to his job which entailed lifting, bending or agility of movement. The employer would, or could, offer no lighter work and the stage was set for a deadlock. After a period of idleness, the victim consulted a lawyer of reputation in personal injury claims who referred him to a physician of court reputation. At this time x-rays showed "arthritis" or some other common abnormality of the vertebral column.

There are now two strikes against the insurer; no immediate x-rays had been made or, if they had, no attempt had been made to explain to the patient and the insurer preexisting conditions that might have been aggravated by the injury or delayed recovery from it. No effort had been made to fit him into a job that would serve until the temporary effect of the injury had subsided. The third strike is sure to be called by the jury when these peers have been convinced by the plaintiff's expert witness that he is totally and permanently unable to resume his former occupation because of the arthritis or other abnormality claimed to be caused or aggravated by the injury.

The Author

● **Dr. Willis, now retired, was formerly head of the Department of Orthopedic Surgery at St. Luke's, Charity, and St. Alexis Hospitals, and former consulting orthopedist, USPHS Hospital, Cleveland.**

Joint Reactions to Injury

Joint structures react primarily to physical injury in the same manner as to other irritants, such as bacterial infection or metabolic toxins, with heat, pain, edema, increased production of synovial fluid, restriction of mobility and protective muscle spasm. If the irritating agent is transient, as is a single trauma, the reaction is temporary and, if allowed rest and protection, gradually subsides. It the joint is further irritated by undue activity, disturbed dynamics or interruption of its blood supply, the symptoms persist and progress.

Such a course is readily observed in the more accessible joints of the limbs and is diagnosed *Traumatic Arthritis.* The intervertebral joints are deeply situated and well protected from direct contusions but are subject to sprains. If their dynamics are disturbed, mechanical irritation persists and an acute arthritis caused by a single injury may become chronic.

All types of arthritis have been attributed to injury. Theoretically, pathogenic bacteria circulating in the blood or lymph, or quiescent in contiguous bone, may be localized in joint tissues by trauma and develop acute or chronic infections according to their natures. Whether or not one concurs in this theory, it has been recognized in court. While it cannot be categorically denied, one

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must insist that such *Infectious Arthritis* originates at the site of injury and follows a course characteristic of the invading organism in chronology, systemic and pathologic symptoms. Unless compounded, injury alone does not cause infectious arthritis. At most it may localize or aggravate a preexisting infection.

Chronic arthritis, either infectious, traumatic or metabolic, may be well established before injury calls attention to it. It must have been present for some time before tissue changes are shown by x-ray.

Emotional Element of Arthritis

Rheumatoid Arthritis, one of the most prevalent of chronic diseases, is an inflammatory lesion of unproven etiology which may be present but unrecognized until activated by trauma, exposure, fatigue or even by depressive emotional crises. This is a systemic disturbance, its joint symptoms apparently due to a presently unidentified protein toxin of metabolic orgin to which specialized connective tissues are particularly susceptible.

That this conjectural toxin may be increased, or that the individual patient's detoxifying function may be diminished, by prolonged emotional depression, is a frequent observation. The writer has so often seen both subjective and objective symptoms of an arthritic patient, who had been progressing satisfactorily, seriously aggravated following advent into the home of a critical or domineering relative that he has been tempted to dub the condition "Mother-in-law's Disease." The balance of health is similarly upset by social, financial or economic stresses, and the symptoms frequently subside when the irritant is removed or psychological adjustment has been made to it.

Small wonder then that, in susceptible individuals, emotional depression due to injury, loss of employment and loss of income so frequently obligated to credit buying, starts a vicious circle activating rheumatoid arthritis. Though not caused directly by injury, this type of chronic arthritis is liable to aggravation by either physical or mental factors.

Misnamed osteoarthritis is characterized by medullary osteoporosis, calcification of ligaments and friabilization of cartilage, all of which are degenerative, not inflammatory, changes associated with vascular stasis. They are frequently seen in x-rays of backs of individuals who have been performing heavy labor with no evidence of disability. Such changes are certainly not caused by a single injury, but their presence indicates predominance of degenerative processes and susceptibility of the back to injury with delayed recovery.

What about the calcifications that we point out to patients roentgenographically, sometimes I fear, giving them the indelible impression that here is the source of their pain and disability? In 1924[1] the writer discussed them as found in the macerated skeletons of 625 dissecting room subjects, arriving at the conclusions that they were signs of age appearing at about the 35th year and progressing steadily with time; that they appear earlier and develop more extensively in broad, heavy vertebrae, and that clinical experience indicates that strenuous physical activity accentuates their growth. He still maintains these opinions and believes that, when pronounced, the degenerative condition of which they are evidence affects the stability, mobility and vulnerability to injury of the vertebral column, but that if pain appears injury or rheumatic complications are to be suspected.

Macnab, Harris and Lauren[2] have recently stated that these spondylophites, of which they describe five types, are always associated with degenerated intervertebral discs; that they form and progress only in the presence of local movement and, since they ultimately immobilize the vertebral joints, are self-limiting. They find no constant relationship of spondylophites to posterior vertebral joint arthritis, and attribute any pain associated with them to anatomical instability or arthritis.

Medical-Legal Concurrences

The relationship of vertebral arthritis to injury is primarily a medical problem, but due to its legal implications, has acquired major importance in personal disability litigation. Medical opinion is in general, founded on experience, the success or failure of various procedures to relieve a patient's complaints, and is constantly changing with new discoveries. Legal opinion, though progressive, is founded largely on precedent, decisions arrived at in previous considerations of similar problems. The two professions have arrived at certain agreements in respect to the problem under discussion. For instance:

The Swiss National Accident Fund[3] has decided that:

1. The fact that the patient had no incapacity before the accident is not absolute proof that the joint was previously intact, but a roentgenogram showing arthritic deformity is proof of previous latent disease.

2. Arthrosis may follow an accident that is particularly violent, causes marked damage to cartilaginous structure and is followed by serious local trophic changes or prolonged irritation.

3. Minor traumas, such as torsions, contusions and injuries to soft parts cannot possibly cause

deforming arthropathy, but may set off an attack if the disease existed previously.

4. A bout of arthrosis following trauma will usually subside under proper care, and joint function will be largely restored.

5. In general, only those joints directly injured will be the site of post-traumatic arthrosis.

6. The disease rarely spreads to neighboring joints, even if they form a static unity with the involved joint.

7. The lapse of time between injury and the first clinical or roentgenological manifestations of arthrosis is determined by the nature and extent of the injury and the age and susceptibility of the patient.

8. If post-traumatic arthrosis disappears completely, the accident cannot ordinarily be invoked as the cause of future attacks of arthrosis, especially if they do not occur until much later.

9. Arthrosis is a disease of wearing out and is therefore more truly pathological when appearing in younger folks.

The Ontario Workmen's Compensation Board[4] has arrived at conclusions quite similar to these:

1. Degenerative arthritis of the vertebral column occurs frequently after the age of 35 but is essentially asymptomatic in 80 per cent of affected individuals. Radiological changes are proof of the disease but have no correlation with the presence of disabling symptomatology.

2. Trauma may aggravate a preexisting arthritis and be responsible for its exacerbation for an arbitrary period of six months.

3. Trauma is not recognized as the cause of arthrosis or of aggravations recurring 6 to 36 months after the injury.

4. The board accepts a limited degree of responsibility for arthritis associated with intervertebral disc injuries, fractures and spondylolisthesis. Also for arthritis associated with and localized at, vertebral fractures, disturbed joint dynamics, aseptic necrosis and nonunion.

5. The Board finds no proof that Marie-Strümpell disease is speeded up by trauma.

6. Trauma does not play a role in the development of rheumatoid arthritis but may aggravate a preexisting lesion.

7. Gout is not caused by trauma but trauma may aggravate or precipitate an attack. Responsibility is accepted for the original attack only.

Medical-Legal conclusions in the United States are closely in agreement with the foregoing opinions and have been well summarized in the following citation by the Supreme Court of the State of Washington[5]: "Where a compensable injury lights up a dormant or quiescent arthritis the injured workman may be compensated for the full extent of the disability occasioned by the arthritis so lighted up." Then this pertinent sentence is added: "The extent of the disability attributable to compensable injury, as it exists at any relevant time, must be determined by medical testimony, some of which must be based on objective symptoms."

Here is the crux of the problem, dropped squarely in the lap of the medical profession. Here is the test of a medical witness's intelligence and integrity; his ability to render an opinion based wholly on his professional knowledge, regardless of personal interest and motives.

Proof of Disability

Estimation of the degree of disability attributable to arthritis or to injury of the back, or of the aggravation of one by the other, may be difficult or impossible, even if there exists a record of the pre-traumatic condition of the back. Meticulous disability rating schedules have been prepared and are of value as general guides, but ultimately each individual claim is reduced to careful appraisal of subjective symptoms and comparison of these with any objective evidence available and with the victim's pre-traumatic record if, by good fortune, such exists.

Disability of the joints of the extremities can be demonstrated and estimated in relation to stability and mobility of the part, but how important is mobility of the back? Assembly-line workers, machinists, stenographers, even professional weight lifters perform with their backs straight. A back ankylosed in extension by Marie-Stümpell arthritis is not severely disabled if the neck, shoulders and hips are mobile.

Stability is a more important back factor than is mobility, but how can one satisfactorily manipulate a back to determine it? In no other part of the body is an examiner so dependent upon subjective symptoms and x-ray findings. In no other part do x-ray films show so many abnormalities that may, or may not be of etiological import.

When there has been a fracture or other diagnosable injury the ensuing disability can be estimated with a degree of confidence, perhaps by recording the degrees of deformity, mobility and stability on punch-cards and feeding them to a computing machine. Unfortunately there will still be differences of opinion among the card punchers. Even greater will these differences be when the injuries are less definite and are associated with arthritis and other complications.

Long periods of disability are almost certain to be associated with exaggeration and malingering. These can be detected by careful observation. Only a well instructed expert can assume the attitudes characteristic of back injuries, and he cannot maintain them while performing the movements required in back examinations. Refusal to attempt such movements is as reliable evidence of malingering as is invocation of the fifth amendment in political trials.

The borderline between actual and conscious or subconscious exaggeration of disability is indistinct and here is a field for honest divergence of medical opinions. Here too, is a fertile and safe field for propagation by the occasional unethical and dishonest physician and attorney. How can one disprove the veracity of an expert opinion stated under oath? A hospital tissue committee may prove errors of diagnosis and judgment, and withdraw a physician's hospital privileges because of them, but it cannot disprove his sincerity in making them. A medical society's investigating committee may disagree radically with a witness's expressed opinions but it cannot well prove they were perjured.

A juror is justifiably confused by the contradictory testimony of medical expert witnesses, and by testimony couched in technical terms and jargon. Having no knowledge of anatomy, physiology and pathology, he is more impressed by the witness's personality and assurance than by the substance of his testimony. He is apt to consider the less convincing witness a member of a partisan team rather than impartial.

A Court Appointed Expert Witness

If the court considers the testimony of medical witnesses too divergent to represent honest differences of opinion it has the authority, subject to the laws of its state, to subpoena and remunerate experts of its own choice. It is probable that jurors would give more weight to the testimony of a court appointed expert than to those whom they must consider partisans.

I suggest that this judicial privilege be employed more frequently. The court appointee should be allowed to examine the patient and review the testimony of the other physicians and confer with them personally if he so desires, before taking the stand. Still better, because once testimony is recorded it cannot well be changed, when it is known that there will be radically differing opinions, the court appointment and medical conference, including examination of the patient in the presence of the opposing attorneys as silent observers, could precede taking of medical testimony. I doubt that a partisan witness, if there be such, would venture so far out on a limb of biased opinion under such circumstances as he might otherwise. No witness would be bound in his testimony by the opinion of the conference but consultation is a valuable procedure in any medical problem and might lead to more careful consideration by all of the experts.

A number of state and county medical societies have attacked the problem of medical testimony. Minnesota, for instance, has had for a number of years a committee with authority to review trial testimony, to confer with the witnesses and report to the society any questionable findings. The New York Academy appoints a panel from which witnesses may be chosen by the Court.

Plans of this sort should be universal and based on the local state laws, some of which probably need altering. The committees should investigate as thoroughly as possible the instigation of each suit. Many are due to inconsiderate action by the physician, some to unethical legal practices, others to the intolerance of either the plaintiff, defendant, employer or insurer.

I suggest also that attorneys handling personal injury claims, during examination and cross-examination of medical witnesses, make sure that even the dullest of jurors understands the problem under discussion and the statements of the witnesses. This can be better accomplished by insisting that technical language be avoided as much as possible and by presentation of anatomical material, models or colored charts illustrative of the parts involved. These could be prepared by health museums or medical schools and made available by loan, rental or subpoena.

Detrimental Effect of Litigation

Three parties are originally concerned in the problem of injury and spinal arthritis: the patient, the physician and the employer. The most important objective in the viewpoint of all three should be prompt and efficient treatment of the patient. This implies meticulous examination and recording of all findings, including x-rays, no matter how minor a back injury may seem; frank discussion with the patient and the insurer, in understandable language, of the injury and of preexisting conditions such as arthritis and anomalies that may affect the progress of the patient and his restoration to useful employment.

If there is to be a permanent disability, either partial or total, a prompt settlement of the claim directly with the patient is best for all concerned.

Every effort should be made to avoid litigation and the deleterious effects of two or three years of vindictive idleness and exaggeration of symptoms, during which the patient's employability and morale are disintegrating.

Certainly an employee or insured individual who has legally proven, or even attempted to prove, himself partially or permanently disabled, is handicapped in obtaining further employment or insurance. By litigation he has also gambled his claim for rehabilitation and job adjustment and his medical expenses against an uncertain number of dollars. Of even more importance, he has compromised the moral stamina necessary for his resumption of normal living.

Though 95 per cent of personal injury claims coming to litigation against railroads are decided in favor of the plaintiff, he may well be better off financially through direct settlement of his claim with the defendant, and at the same time escape the detrimental effect of litigation. Two hundred and four personal injury claims, including fatalities, single and double amputations, were settled directly with claimants by five railroads in different sections of the country for an average of $21,541.99. The estimated net proceeds for the victims of 255 similar accidents settled by litigation averaged $19,949.74[6].

From the court award, if he wins the contest, the claimant must subtract one-third or one-half for his attorney's fees, and if not insured, the costs of his treatment, also the intangible physical and moral effect of the long period of inactivity and the detriment to his future employment. The defendant must add to the court award the costs in money, time and employee morale of defense. The only clear profit from litigation is that of the plaintiff's attorney, usually contingent upon victory, and of the expert witnesses, which is at times a bit odorous.

Responsibility for Injury

The claimant must realize that his injury was accidental, perhaps due to his own carelessness; the employer, that the workman was injured in his service and must be restored to useful employment; the insurer, that his policyholder is entitled to the protection for which he has paid. The attorney must know that greed and malingering are not to be condoned and that prolonged idleness and exaggeration of disability are harmful to his client far beyond the value of additional dollars that may be acquired by litigation. The physician must remember that it is his duty to restore his patient to useful activity as rapidly as possible, not to pervert the truth to win court decisions either for or against his patient.

Finally, the court must discover a means of lessening the delay in hearing those personal injury claims that come to litigation; a delay extremely detrimental to all parties concerned in the problem.

Summary

One of the most frequent and difficult problems of personal injury litigation is determination of the degree of disability following injury of an arthritic back, the relation of the arthritis to the injury, and the percentage of disability attributable to each of the factors.

Though all types of arthritis have been claimed to be caused, or at least aggravated, by injury, the type most often involved is osteoarthritis, the degenerative lesions of which appear regularly in middle age and are shown in x-rays as osteophytes, calcifications and thinned cartilages.

An aging back is more susceptible to injury and slower in recovery therefrom, but the effect of injury is temporary unless the dynamics of the back are disturbed.

Complex rating schedules are of but little value in determining back disability because the symptoms are mostly subjective, x-rays show degenerative changes and abnormalities that may, or may not, be of etiological importance, and because claims of disability that drag through litigation are certain to involve conscious or subconscious exaggeration of symptoms or even deliberate malingering.

Meticulous examinations may lead to honest divergence of medical opinions that confuses jurors. Testimony of a witness appointed by the court and intelligently presented would no doubt aid these peers in arriving at a reasonable verdict.

For the physical, moral and long term financial welfare of the patient, and for the good of the employer and insurer, it is best to settle personal injury claims promptly and fairly without litigation. Medical and legal organizations must continue their efforts to aid the courts in discouraging the occasional shyster and perjurer who pervert justice for financial gain.

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MATERNAL HEALTH IN OHIO

TOPIC THIS MONTH:

Maternal Deaths* Involving Pulmonary Embolism

Case No. 152

This patient was a 28 year old Para II, abortus I, who died 10 days postabortal. Her past history showed the patient had had hypertension three years previous, during her first pregnancy in 1953. Little is known concerning her treatment at that time. The first and second pregnancies were presumably delivered at term, with toxemia the sole complication. Her last menstrual period was November, and, according to the data available, she made only one prenatal visit to her physician. The date of this visit is not known.

It was stated that her blood pressure reached a high of 220/130, and albuminuria and edema are not noted. The details of the onset of her labor are not known. She was admitted to the hospital on February 19, with apparent hypertension, although details of her physical examination are not known. It was stated that the patient was markedly obese. Laboratory studies are not reported.

Upon admission in her fifteenth week of pregnancy she was placed under extensive treatment and Ansolysen,® after a trial with other therapy had failed. Details of the treatment and laboratory procedure are not available. Finally, her blood pressure diminished rather rapidly, and after the medication was stopped the patient failed to elevate her blood pressure again. A renal shutdown ensued. The nonprotein nitrogen of the blood elevated; electrolyte balances became unstable, and the patient spontaneously aborted on March 12 (at 18 weeks). Details of these facts are not recorded.

With the patient later demonstrating relative hypotension, Levophed® was administered, blood pressure was maintained just above shock, but it could not be sustained for any length of time. The last nonprotein nitrogen of the blood was 156 mg. On March 21 she suddenly expired. Autopsy permission was not obtained.

Cause of death: Acute pulmonary embolus; phlebothrombosis, pelvic; spontaneous abortion (20 weeks); malignant hypertension; acute renal failure; paralytic ileus.

Comment

Members of the Committee felt markedly hampered in their efforts to properly evaluate the features in the case because of the lack of adequate details in the history, physical findings and laboratory work. It is regrettable that an autopsy could not have been performed to more clearly diagnose the cause of death. The question of nephritic syndrome developing prior to demise of the patient was properly raised. The Committee further raised the question of whether or not appropriate therapeutic agent was employed, in view of the pathological and physiological features in the case. It was also felt that the patient should have been advised not to become pregnant for a third time, in view of the severe hypertension that she previously experienced. Considering the meager facts and features presented, the Committee voted this a preventable maternal death.

Case No. 182

This patient was a 37 year old, Para XI, who died six days postpartum. She had 10 previous pregnancies, with no history of any difficulty recorded. Her past history was not known, and her last menstrual period was not recorded. She did not seek prenatal care, but was first seen by a physician for this pregnancy at term on the delivery table on June 30. Essential physical findings were: obesity; blood pressure 180/110; severe varicose veins of the legs, and internal and external hemorrhoids. Labor progressed uneventfully and with open drop ether anesthesia administered by a nurse, she delivered a stillborn infant weighing 8 pounds, 6 ounces. On July 1 the patient signed her release and left the hospital.

July 6 the patient was again seen in the emergency ward in extremus. No interim history could be obtained. Death ensued without the opportunity of any treatment and was attributed to pulmonary embolus. Autopsy permission was not granted.

Cause of death: Pulmonary embolus; obstetrical delivery.

Comment

The Committee voted this a preventable maternal death classified as the patient's responsibility. The possibility of development of thrombosis in the legs, hemorrhoidal vessels or in the pelvic vessels was seriously considered. Again, the Committee was hampered in evaluating the details in the case, since there were only meager data available and

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*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by official representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

no autopsy. The patient's responsibility was assessed in this case because of her lack of prenatal care and her insistence on being discharged after the delivery, although with meager facts available, it was hard to construct a physiological or pathological process preceding death. It was felt that had she presented herself to a physician at an early date for examination the thrombotic phenomenon might have been anticipated and a pulmonary embolus might have been prevented, if that was the cause of death.

Case No. 192

This patient was a 22 year old, Para III, who died 54 hours postpartum. In her past history there was nothing remarkable. However, she had had two previous cesarean sections at term, which were believed to be classical; indications not available. The first was complicated by postoperative bronchopneumonia. The date of the patient's last menstrual period is not known. However, the patient is believed to have had adequate prenatal care, with 10 visits to her physician's office.

According to the information obtained, the patient was admitted (near term) to the hospital August 5 for an elective cesarean section the following day. No details are given concerning her physical examination or her laboratory work. On August 6 the patient submitted to an elective classical cesarean (repeat) section under vinyl and ethyl ether anesthesia. According to the record, this was administered for 75 minutes. A living 7 pound 6 ounce baby was delivered without immediate complications.

At some time after the operation, the patient developed pneumonitis and bronchiolitis on the right side. She was immediately placed on Alevaire,® penicillin, and streptomycin. Her general condition temporarily improved. On August 7, the patient developed supraventricular tachycardia with regular pulse; pulmonary condition seemed to improve. She developed gastric dilation, and nasal suction was started. Panmycin® was administered, and on August 8 at 1 a. m. the patient was resting comfortably. Her pulse was rapid and regular; her color was pasty. Suction working well with soft abdomen. Rales and dullness were exhibited over right lower chest. At 1:30 p. m. there was sudden deterioration, marked cyanosis and dyspnea. The patient died at 1:35 p. m., August 8. There was no autopsy.

Cause of death: Pulmonary embolism, postoperative; supraventricular tachycardia; pneumonitis, postoperative; cesarean section.

Comment

Again, the Committee was profoundly hampered by the lack of detailed information concerning examination of the patient and by a lack of authentic information. Members of the Committee wondered if consultation had been obtained prior to this operation, in view of the pulmonary complications following the first cesarean section. Since the patient was assumed to be in good health and excellent condition prior to her operation, it is only a matter of conjecture to ascertain the source of the embolus, if that *was* the cause of death. Again, in view of a history of pulmonary complication, the wiseness in a choice of an anesthetic was questioned. However, in view of the facts presented, the Committee voted this a nonpreventable maternal death.

Comment of Consultant

The following comment of a consultant, a specialist in thoracic and cardiovascular surgery, was given at the request of the Committee.

To blame pulmonary embolism as a cause of sudden death without postmortem examination is fraught with danger. Most of us are aware of many patients who have died suddenly and in whom our pre-autopsy diagnosis was pulmonary embolism. Examination, however, would show a different cause for death or in many instances no exact cause could be visualized. In like manner, many cases of sublethal embolism take place without being diagnosed. The classical symptoms of shortness of breath, sudden chest pain, pleural friction rub, and hemoptysis are found in only 15 per cent of the cases which are proven by autopsy. Similarly, the wedge shaped pulmonary shadow seen on x-ray examination is the exception rather than the rule. The pain and tenderness over the deep veins of the calf may be quite minimal at the time a loosely fastened clot is released into the venous stream. And how does one diagnose an early thrombus floating in the pelvic veins?

The surgical removal of massive pulmonary embolus from the pulmonary arteries has proven to be unsatisfactory. Present-day measures consist of treatment similar to that of acute coronary occlusion.

For a time there was much talk and a beginning series of bilateral femoral vein ligation immediately following a suspected pulmonary embolus or even as a routine preoperative measure. Subsequent autopsy studies of McLachlin and Paterson showed that 50 per cent of the thromboses were located in the deep veins and that bilateral femoral ligation would not guard against pulmonary embolus. Vena cava ligation had its proponents also but the increased morbidity of this procedure has decreased its value.

At the present time the cycle has returned to its starting point, that of anticoagulant therapy. Coon et al. reported in the February, 1958, issue of *Surgery, Gynecology and Obstetrics* on the exhaustive study at the University of Michigan. Among the total of 511 patients, 21 had pulmonary emboli during anticoagulant therapy, causing seven deaths. After anticoagulant therapy was discontinued, 16 additional patients were diagnosed as having pulmonary emboli, with eight deaths.

It was equally discouraging to learn that (1) initial heparinization, (2) duration of anticoagulant administration, and (3) the level of "prothrombic activity" have no critical influence on the rate of complications from peripheral venous thrombosis. The article ends, however, by stating that different authors report a decrease of 50 per cent in mortality and morbidity in comparison with a series of patients with no treatment at all.

Case No. 152: Implicating pulmonary embolism as a cause of death in a patient such as this with renal shut down is debatable. In fact, these patients generally show just the opposite, namely difficulty in controlling hemorrhage from operative wounds, skin, and mucosal surfaces. This is preceded by a lowered prothrombin, lowered platelet count and an increase in capillary fragility.

The duration of hypotension necessary to produce renal shut down is certainly less than 30 minutes and can readily take place during anesthesia in an arteriosclerotic patient with moderate blood loss or in a debilitated patient with a low blood volume. Although one can never accurately predict a patient's reaction to any certain drug, the rate of administration of the drug could possibly have been altered to obviate any sudden changes in blood pressure during the administration of this hypotension producing agent. Lowered cardiac output with resulting impaired venous return is a perfect setup for venous thrombosis. Without any symptoms of pulmonary embolism except sudden death, I fail to see how death from this cause could be prevented. However, I think the death was preventable on the basis of overtreatment of hypertension with a hypotensive agent.

Case No. 182: One might reason that if this patient's legs were wrapped with elastic bandage for the first two weeks postpartum, the chances of phlebothrombosis and thrombophlebitis occurring would be lessened. However, to routinely treat all postpartum patients having varicose veins and hemorrhoids with anticoagulants would be unsound. One tenth of all patients treated with these agents will experience bleeding tendencies of such magnitude that proper countertherapy becomes necessary.

It would be interesting to know if this patient practiced early ambulation like one might expect since she signed her release. Early ambulation to varicose veins without external support is probably as dangerous as bedrest with elevation of the leg. On this basis, death was possibly preventable.

Case No. 192: A history of bronchopneumonia following the initial section should weigh heavily in one's choice of anesthesia. Spinal anesthesia does not obviate pulmonary complications but does lessen their incidence. In addition, strenuous postoperative positive pressure breathing, forced laughing, aerosolization of antibiotics and the parenteral administration of antibiotics should have been given as a routine upon awakening rather than waiting until the patient became symptomatic. The value of endotracheal intubation for endobronchial suction as well as oxygenation should be kept in mind if general anesthesia is undertaken. The rapid onset of symptoms in this patient within 24 hours of delivery makes the diagnosis of pulmonary embolism doubtful. Aspiration pneumonia or bronchopneumonia would seem much more likely, and on this basis I believe the death was preventable by changes both in anesthetic techniques and in immediate postoperative care.

Selective Readings

The Riddle of Stuttering, by C. S. Bluemel, M. D., ($3.50, *Interstate Printers and Publishers, Danville, Ill.)* There are a number of components to the riddle of stuttering. The personality of the speaker must be considered. As a rule the stutterer is self-conscious, tense, excitable, and easily confused. Because of these characteristics—and because of speech phobia which develops later—there is a good deal of "fluster and scatter" in the verbal thinking and thus the mind may be mute when the stutterer attempts to talk. Not understanding these inner difficulties, the speaker attempts to force the articulation of his words, and the effort leads to struggle and contortion. This physical manifestation of the impediment is merely the empty shell of speech. Apart from this impediment, the stutterer is basically a poor speaker. Many stutterers have articulative difficulties in childhood, and as adults they carry a natural speech deficit. Even when a stutterer is talking well he seldom commands normal verbal skills.

Fortunately, therapy is much simpler than the complex structure of the disorder. The speaker does not need to work on his stuttering, he scarcely works on his speech. The therapy is directed to the verbal thinking process and if the stutterer can learn to think quietly and clearly in words, he can then broadcast words to his mouth. Such is the scheme of techniques given in detail in this work.

Albert Schweitzer: The Story of His Life, by Jean Pierhal. ($3.50. *Philosophical Library, New York 16, N. Y.)* Albert Schweitzer is one of the few "universal" men of our time. He has contributed equally to theology, music, medical science, philosophy and sociology. The new authorized biography of this most unusual man describes his childhood experiences, his researches and travels, his suffering and dedication and makes fascinating and inspired reading.

Proceedings of the Ohio Society of Pathologists

Reported by **PAUL N. JOLLY, M. D.**, Cincinnati, Ohio

THE fall meeting of the Ohio Society of Pathologists was held at the Cincinnati General Hospital at 2:00 p. m. on Saturday, September 21, 1957.

Scientific Program

The first of four papers in the Scientific Program was presented by Dr. Benjamin Landing of the Children's Hospital. His subject, "The Histochemical Analysis of Anterior Pituitary Cell Types" indicated an attempt to localize the formation or storage of the known anterior pituitary hormones to the three anterior pituitary cell types. Two methods of study were combined to this end. The first was the histologic and histochemical study of the anterior lobe before and after various digestion and extraction methods. The second was the histochemical study of the various reactive groups of four of the anterior lobe hormones. The accumulated data separated four to eight proteins in the acidophiles and three to four proteins in the basophiles. None of the proteins so separated could be equated with any known animal hormone of anterior pituitary origin.

"Histochemical Study of Enzyme Activity of Leukocytes in Health and Disease" was the subject presented by Dr. Herbert Braunstein of the Cincinnati General Hospital. He gave a brief historical review of the histochemical demonstration of enzyme activity in leukocytes from the demonstration alkaline phosphtase in mature neutrophiles in 1947 to current studies utilizing acid and alkaline phosphatase and esterase. The demonstration of phosphatase in myeloid cells, of esterase in the monocytes and the absence of these enzymes in lymphocytes provides a useful tool in the chemical identification of cells which may be morphologically similar in various infectious and neoplastic diseases.

"Extensive Arterial Damage Induced in Rats by ACTH" by Drs. Benjamin Miller and Bernard Wexler of the May Institute, affiliated with the Jewish Hospital, was presented by the latter. The observations presented arose from an experiment designed to check the regenerative power of the remaining kidney in old and young rats subjected to unilateral nephrectomy.

Administration of steroids and ACTH in various combinations for 48 days after the nephrectomy produced hypertension in the older animals but not in the young rats. No gross vascular abnormalities were seen in the young rats but histologic abnormalities included perivascular accumulations of red material and some swelling of the myofibrils. Vascular changes in the older animals were extensive and included disseminated arteriosclerosis, ectasia of the aortic arch with aneurysm in the ascending segments and organizing iliac phlebothrombosis. Histologic changes included fragmentation of the myofibrils, loss of elastic fibers, medial calcification and chondroplasia, an increase in the interlamellar bridges, a swelling of the ground substances and intimal proliferation.

Dr. Boris Gueft's topic was "Abnormal Human Liver Under the Electron Microscope." The present models of the electron microscope have a maximum resolving power of 5A° and a practical resolving power of 30A° in contrast to the original design of 25 years ago which had a resolution of 0.5 micron. With a series of electron photomicrographs of abnormal human livers he illustrated various patterns of cytoplasmic and nuclear detail, and indicated areas in which the accumulated information suggested a value in differential diagnosis.

Abstracts of Cases from Slide Library

Case 627: Presented by Dr. B. S. Black-Schaffer, Cincinnati General Hospital.

A 30 year old housewife was hospitalized because of dyspnea and cyanosis. She died 15 hours later. The patient had always been in good health with normal blood pressure. Six months before entry, she awoke one morning with an aching pain in the left anterior chest and in both shoulders. She entered the hospital for study two months later. The findings at that time were an enlarged heart, a to and fro murmur over the aortic area, and a loud and snapping second pulmonic sound. Blood pressure was 150/0. There was a Corrigan pulse. Serologic tests for syphilis, L. E. preparations and blood cultures were all negative. Sedimentation rate was 32 and antistreptolysin titre 12 units. EKG showed prolonged A-V conduction and left ventricular hypertrophy. Digitalis, ACTH, and antibiotics were of little help.

Two weeks before admission, mild precordial pain and bouts of nocturnal dyspnea were experienced. On the day of admission she had right anterior lower chest pain, cough, and hemoptysis, dyspnea, and cyanosis. She was re-hospitalized and found to be cold and cyanotic. Blood pressure was 70/0. Despite supportive measures Cheyne-Stokes respiration supervened and the patient died.

Diagnosis: *Chronic nonspecific aortitis.*

Case 628: Presented by Dr. Paul Wozencraft, Cincinnati General Hospital.

A 41 year old Negro was hospitalized on September 21, 1956, because of increasing dyspnea of one year duration. At the age of 21, the patient was observed in the clinic with a penile ulcer, and later, venereal warts. He had also had gonorrhea. Serologic tests for syphilis, repeated many times, were negative. Physical examination revealed severe dyspnea. Pupils did not react to light or accommodation. Respirations were 44/m. Blood pressure varied from 180/90-40 to 215/70-0. The heart was enlarged. A loud diastolic murmur at the base was transmitted to the apex and a loud systolic murmur at the apex was transmitted to the axilla. The liver was down 3 fingerbreadths and there was edema up to the knees. Blood counts were normal. The urine showed 4 plus albumin and occasional white cells in the sediment. Serologic tests for syphilis were again negative. X-ray revealed fluid at both lung bases. The patient died two days later.

At autopsy the heart (755 grams) showed global hypertrophy and dilatation with evidence of aortic regurgitation. Coronary ostia were elevated. Three healed intimal tears were identified; one at the posterior sinus of Valsalva, and two immediately above the aortic valve. The kidneys were enlarged (right 225 grams and left 275 grams). Capsules stripped with ease and cut sections were not remarkable.

Diagnosis: *Syphilitic nephritis of Rich.*

Case 629: Presented by Dr. Herbert Braunstein, Cincinnati General Hospital.

A 4 year old white child was hospitalized because of fever, lethargy, anorexia and rash. The rash started on the face and spread to the trunk. At one year of age, the child showed definite evidence of retardation, both physical and mental. She had frequent colds and her general health was considered poor. The patient had an older sibling with cranial synostosis who was operated upon, but the outcome is not known.

Physical examination showed a girl with grotesque facial characteristics. Temperature 102°, pulse 120, and respirations 38. Supra-orbital ridges were prominent. Nasal bridge was depressed. The neck was short and thick. The liver and spleen were enlarged. There was ankylosis of the glenohumeral joint. The hands were broad and wide, and the fingers were contracted. Morbiliform rash was noted on the face and trunk. On admission, white blood count was 10,000 with 71 per cent neutrophils, 25 per cent lymphocytes and 4 per cent monocytes. Tracheotomy was carried out for respiratory distress. The patient expired the morning following entry.

Diagnosis: *Gargoylism.*

Case 630: Presented by Dr. Paul N. Jolly, Christ Hospital.

A 36 year old white woman had a radical mastectomy for carcinoma in March 1956. Metastases were present in several axillary lymph nodes. The patient became pregnant in August, and at the same time developed signs of osseous metastases in C-2, C-4 and several ribs. Increasing pain finally required hospitalization. Terminally, there were periods of coma with episodes of muscular rigidity and transient tremors. Obstructive type of jaundice was noted shortly before death in January 1957.

Metastases were identified in the lungs, liver, one adrenal and all of the retroperitoneal and mediastinal lymph nodes. The spleen weighed 400 grams and had a pale red pulp containing small, irregular, poorly defined, gray markings.

Diagnosis: *Signet ring carcinoma metastatic to spleen.*

Case 631: Presented by Dr. Benjamin Landing, Children's Hospital.

A 4 year old colored girl was brought to the hospital with hematemesis and melena. She expired the following day. The patient had been delivered spontaneously, at term, in a hospital. Jaundice, which was noted soon after birth, continued to deepen, and at age of three months she was explored. Neither gallbladder nor bile ducts were identified. No procedure was carried out. After discharge, her course was characterized by repeated upper respiratory tract infections. Clubbing of the fingers was noted at age two years. Repeated (5) hospitalizations occurred from age three years to the present admission because of hematemesis and melena. Therapy was essentially supportive.

Laboratory findings during the patient's life were as follows: thymol turbidity ranged from 11 to 39 units; total lipids, 1065-1600 mg.; serum bilirubin (direct/total), 2/12 - 13/23 mg.; alkaline phosphatase, 14-22 Bodansky units. There was a reversal of albumin/globulin ratio terminally. Hemoglobin, 4 grams per 100 ml.; hematocrit, 10. Blood pressure was 80/30. At autopsy no gallbladder nor extrahepatic bile ducts were identified. In place of the gallbladder there was a 1.5 cm. cystic structure which contained clear viscid material. The liver weighed 860 grams. It was nodular (2-5 mm.), and discolored green.

Diagnosis: *Bile duct atresia with cirrhosis.*

Case 632: Presented by Dr. William Collins, Lima, Ohio.

A 49 year old white married woman was hospitalized for repair of a cystocele and a small inguinal hernia. The patient had never menstruated or been pregnant. Several years ago, she had been told that she had no uterus. She had had normal marital relations. She had an unmarried sister who had never menstruated, and a married sister who had had menses but had never been pregnant.

Physical examination revealed a well developed, well nourished woman. Body hair was fine and scanty. There was no axillary hair and only scant pubic hair. The breasts were large, but the nipples were very small. External genitalia appeared to be that of a much younger woman. A palpable mass 4 by 3 by 2 cm. was present in the left inguinal canal.

A left herniorrhaphy was carried out, and a mass resembling testis was found attached to the lower end of the hernial sac. A laparotomy was then performed, and a similar mass was found in the right inguinal canal. No uterus, tubes or ovaries were identified.

Diagnosis: *Gonad of male pseudohermaphrodite.*

Case 633: Presented by Dr. Philip Wasserman, Jewish Hospital.

A 50 year old white woman had several hospitalizations from 1951 to her final admission in November 1956. In 1951, she had metrorrhagia. A supracervical hysterectomy without removal of adnexa was carried out for leiomyomata. Stromal endometriosis was an incidental finding in the resected uterus. Four years later, the patient had vaginal bleeding, and a 2 to 3 cm. mass was felt in the left fornix. A biopsy revealed stromal endometriosis. Radiation therapy (total dose, 1245 r) to the anterior and posterior pelvis was initiated. This resulted in reduction of the vaginal mass.

Late in 1955, she developed neck and chest pains. In addition, a pericardial rub, a grade II systolic murmur at the aortic area, and a grade III systolic murmur at the pulmonic area were heard. X-ray of the chest revealed pericardial effusion and left pleural effusion. Pelvic examination was not remarkable in November 1955. From December 1955 to November 1956 the patient was in fair condition at home. She had hot flashes and was therefore treated with estrogen. Following the estrogen therapy, she developed masses within the lower abdomen and large, purple, grape-like masses filled the vagina. Estrogen was discontinued and there was complete recession of vaginal and abdominal masses.

The final admission was for pulmonary infarction. At the same time, there was an area of absent heart pulsation at the left border of the heart. A pulmonic systolic murmur and a decreased P2 were observed. Prior to death, edema of the lower extremities and cyanosis supervened.

The section is from the heart which showed large masses of yellow-tan tissue infiltrating the myocardium and occluding the pulmonary artery at its origin.

Diagnosis: *Metastatic malignant stromal endometriosis.*

Case 634: Presented by Dr. Jan Schwarz, Jewish Hospital.

A 47 year old laborer was admitted to Hospital

Obrero, Lima, Peru, with an eight month history of repeated jacksonian seizures of the left arm and the left side of the face. Frontal headache accompanied the seizures. The frequency of these seizures increased in the two weeks prior to admission. Physical examination revealed bilateral ocular fundal edema and congestion, more marked on the right side. There was a left hemiparesis with accentuation of reflexes on the same side. A craniotomy was performed, and a 5 cm. mass was excised from the right temporal lobe. The mass was firm, with irregular areas of necrosis.

Diagnosis: *South American blastomycosis.*

Case 635: Presented by Dr. Paul Wozencraft, Cincinnati General Hospital.

In September 1956, an 18 year old girl was readmitted to the hospital with a complaint of painful swelling of the left parotid region. In 1950 she had had an excision of a mass in the same area. Diagnosis at that time is unknown, and slides from that lesion are not available. In 1954 a recurrent painful nodule in the same area was re-excised. On physical examination at the time of admission in 1956, a left submaxillary swelling was also noted. The latter mass was removed. It was nodular and firm with a smooth, lobulated cut surface and a yellowish-pink color. Sections are from the submaxillary mass, which resembles histologically the lesion removed from the parotid area in 1954.

Diagnosis: *Well-differentiated salivary gland carcinoma.*

Case 636: Presented by Dr. Boris Gueft, Veterans' Hospital, Cincinnati.

A 6 year old white boy was hospitalized with fever and vomiting of two days' duration. He was exposed to mumps two weeks prior to admission. One day before admission, he developed fever which was associated with persistent vomiting and headache. On the day of admission he became drowsy and complained of stiff neck.

Physical examination revealed nuchal rigidity, inflammation of the Stenson's duct and left parotid swelling. Deep tendon reflexes were normal. There were no abnormal reflexes. Lumbar puncture showed an initial pressure of 280. The spinal fluid contained 600 cells/cu. mm., all lymphocytes. Culture was negative. In the hospital the patient lapsed into coma and developed clonic convulsions. He regained consciousness only to develop opisthotonos, athetoid movement, and rigidity. He expired eight hours after admission.

Diagnosis: *Mumps parotitis.*

Relationship Between Blood Lipid Levels And Arteriosclerotic Heart Disease

There appeared to be no connection between actual quantitative intake of animal fats and an elevated blood cholesterol level.

The study pointed up the obvious importance of heredity as a factor, particularly when the sibling relationships were studied. The comparison of doctors with sibling histories gave the highest mean cholesterol for any familial comparison.

The study indicates that although it is disadvantageous to be overweight, the condition may not be traceable to the expected causes. It does indicate that a metabolic defect (perhaps dictated by heredity) is involved in the problem of hypercholesterolemia and possible arteriosclerotic heart disease, rather than gross dietary intake of animal fats.—David Taft, B. S., and F. C. Coleman, M. D., Des Moines: *J. Iowa M. Soc.,* 48:293, 1958.

Franklin County Pelvic Cancer Delay Committee Report

By JOHN H. HOLZAEPFEL, M. D.
Columbus, Ohio, Chairman

Following is a summary of cases presented before the Franklin County Pelvic Cancer Delay Committee at the Tumor Conference, University Hospital, on Wednesday June 18th.

Case No. 62. The patient is a 50 year old individual who developed a sensation of constipation and fatigue six months prior to admission. One month prior to admission patient had rectal bleeding. Her family physician did a pelvic examination and found a tumor mass filling the entire pelvis. In the hospital on examination she was found to have an annular constricting lesion 6 cm. about the anus and a mass filling the pelvis. Laparotomy done. Total hysterectomy, bilateral salpingo-oophorectomy carried out. Pathology reported adenocarinoma, site unknown. Carcinoma was found to spread throughout the pelvic viscera.

Comments: (DR. HOLZAEPFEL) — No rectal biopsy was taken, nor was there any record of sigmoidoscopy. The possible origin of rectal adenocarcinoma could not be ruled out. (DR. POMEROY) — Nitrogen mustard therapy was reserved for later palliation. This patient was treated with external radiation. Regardless of the site of origin prognosis is poor. (DR. BOUTSELIS) — This patient's only opportunity for early diagnosis would have been periodic examinations including a Papanicolaou smear, pelvic examination and rectal examination. This disease process was beyond cure at the time patient was first seen.

Patient Delay: Six months.

Physician Delay: None.

Case No. 63. The patient is an 82 year old lady with previous admission to University Hospital two years prior to this admission. No rectal or pelvic examination made on previous admission. Patient transferred to nursing home. Admitted University Hospital in June with far advanced vulvar malignancy and pharyngeal malignancy with submandibular metastasis.

Institutional Delay: Two years.

Comments: (DR. POMEROY) — It is of interest to note that when this patient reported to X-Ray Department no note is recorded on the chart of any positive findings on laryngoscopy or by palpation of the throat. (DR. BOUTSELIS) — This patient had some type of vulvar lesion two years ago. At age 82 the lesion would not have spread so rapidly that there would not have been malignant or pre-malignant lesion two years ago. (DR. HOLZAEPFEL) — The fact that no pelvic or rectal examination was done on the patient on her previous hospital admission sets the delay entirely on the shoulders of the institution.

The modern treatment of hypertension is a source of hope to the hypertensive patient and of enthusiasm to the clinical investigator.—*J. Arkansas M. Soc.,* 55:31, June, 1958.

Crash Injury Project . . .

Ohio Physicians Are Asked To Cooperate in This Program Sponsored by Professional and Highway Groups and Aimed at Reducing Traffic Toll

UNDER way in Ohio is an automotive crash injury research project in which Buckeye State physicians are asked to cooperate so that information gained from the survey may help to uncover methods of reducing accident tolls.

Known as the Ohio–Cornell Automotive Crash Injury Research Project, it is being sponsored jointly by the Cornell University College of Medicine, New York; Ohio State Highway Patrol, Ohio Department of Highway Safety, Ohio Committee on Trauma (American College of Surgeons) and the Ohio State Medical Association.

The program started July 1 in a selected group of counties. After six months, it will be moved to another group of counties for a similar period, with that schedule to be followed for a three-year period. Interpretation and evaluation of the data obtained will be made at the Cornell Research Center in New York.

Auto Accidents Only

All automobile accidents involving personal injury or death that the State Highway Patrol investigates are reported. No truck, bus, motorcycle or pedestrian accidents are included. Mechanical and physical aspects of the accidents are reported by the Patrol. Medical information is reported by the physician called in on the accident.

When a physician is called in, the Patrolman investigating the accident will provide the physician with a form on which the medical information is to be recorded. The physician is to complete the form and mail it to Dr. Tom F. Lewis, Medical Coordinator, Crash Research Program, Mount Carmel Hospital, Columbus, Ohio. The investigating officer's report is mailed to Highway Patrol Headquarters in Columbus.

The medical coordinator indexes each report and forwards it to the Cornell Crash Injury Research Center, and Patrol Headquarters follows the same procedure with the investigating officer's report.

All information provided by physicians is treated as privileged medical information used only for research purposes. The medical report form contains a perforated section on which the names of physician and patient are entered. Once the research center records the report on IBM punch cards, the perforated section is torn off and destroyed. This is to preserve the anonymity of persons involved.

The program started July 1 in 16 counties, those being Hancock, Putnam, Henry, Wood, Allen, Hardin, Lorain, Medina, Summit, Ashland, Wayne, Athens, Meigs, Vinton, Hocking and Cuyahoga, excluding Cleveland.

At the 1958 Annual Meeting, the OSMA House of Delegates resolved that all Ohio physicians be urged to cooperate in the program.

President Woodhouse has sent a letter to all physicians in those counties, pointing out that "it is hoped this important project will yield a new type of information needed by engineers and safety groups who can put it to use in an attempt to solve the gigantic auto injury problem.

"Your participation is earnestly recommended by the Ohio State Medical Association's Traffic Safety Committee, which believes this is one of the finest projects set up to date to try to find the answer to the auto crash injury problem. Please cooperate." Other OSMA members will receive similar letters when the program moves into their areas.

The Cornell University Medical College has included Ohio among 16 states being studied.

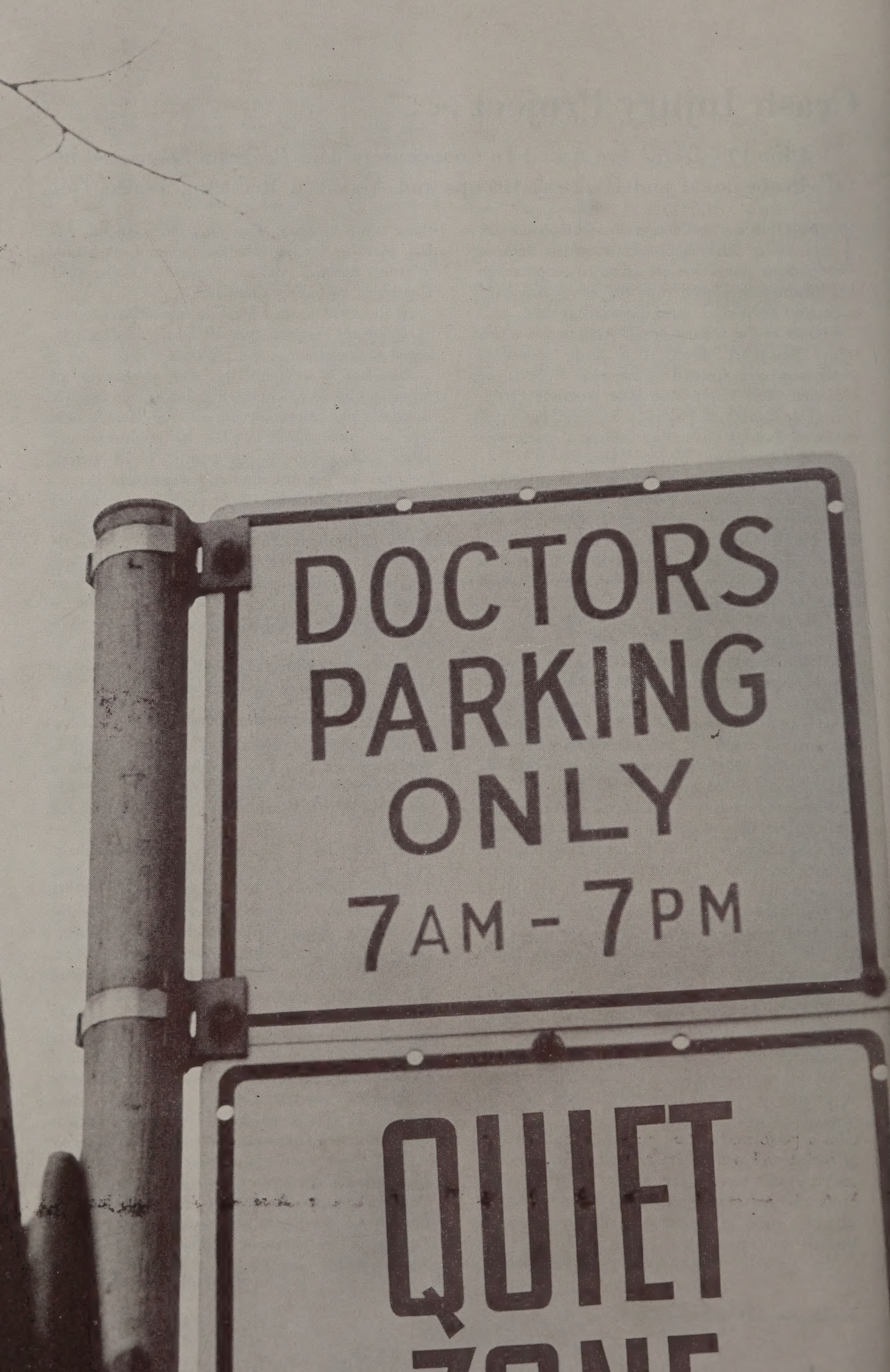
Committee Named

As a result of the House of Delegates resolution, which also directed Dr. Woodhouse to appoint a special traffic safety committee of the OSMA, the President has named to the committee the following:

Dr. Nicholas J. Giannestras, Cincinnati, chairman; Dr. Lewis, Drs. Robert E. Zipf, Dayton; John F. Tillotson, Lima; F. M. Douglass, Toledo; Eldon C. Weckesser, Cleveland; John R. Willoughby, Jr., Warren; Clark M. Dougherty, New Philadelphia; Dean H. Northrup, Marietta; Charles E. Holzer, Gallipolis; Drew L. Davies, Columbus, and Lester G. Parker, Sandusky.

The first meeting of the committee was held June 15 and out of that meeting came, among other things, a request that all county medical societies establish a Committee on Traffic Safety to work in conjunction with local Citizens' Committees on Traffic Safety. The committee also voted to advise Governor O'Neill of this action.

Drs. Davies and Weckesser represented the Association at the Ohio Citizen Leadership Action Conference on traffic safety in Columbus June 24. Dr. Davies previously represented OSMA at the President's Conference on Traffic Safety in Chicago April 1 and 2.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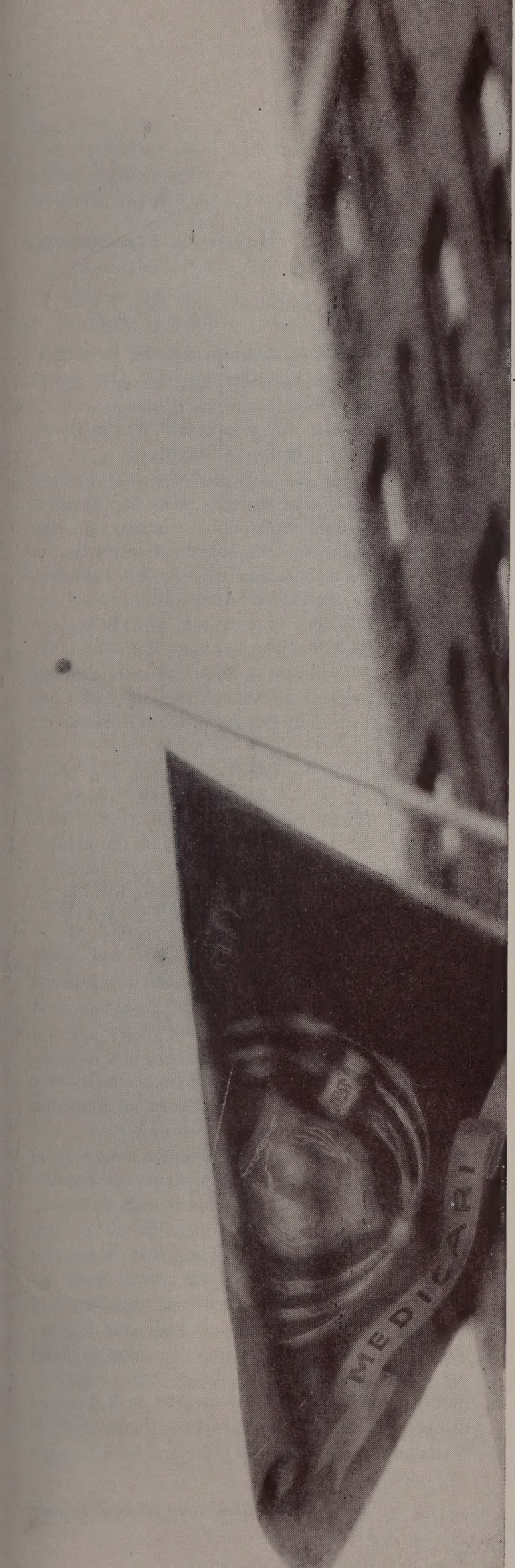

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AMA Session in San Francisco . . .

Ten Ohioans Participate in House of Delegates; Dr. G. A. Woodhouse Reappointed to AMA Judicial Council; Review of Business Transacted

THE United Mine Workers of America Welfare and Retirement Fund, Social Security coverage for self-employed physicians, relations with voluntary health organizations, veterans' medical care, the Medicare program, the Association's Washington Office and over-all legislative system, the medical aspects of hypnosis and the advertising of over-the-counter medications were among the variety of subjects acted upon by the House of Delegates at the American Medical Association 's 107th Annual Meeting held June 23-27 in San Francisco.

Dr. Louis M. Orr, Orlando, Fla., was chosen unanimously as **president-elect** for the coming year. Dr. Orr has been vice-speaker of the House of Delegates and chairman of the AMA Committee on Federal Medical Services. He will become president of the American Medical Association at the June, 1959, meeting in Atlantic City, succeeding Dr. Gunnar Gunderson, LaCrosse, Wis., who became the 112th president at the Tuesday night inaugural ceremony.

The 1958 **Distinguished Service Award** of the American Medical Association was voted to Dr. Frank Hammond Krusen, professor of physical medicine and rehabilitation at Mayo Foundation, Rochester, Minn., for his outstanding achievements and contributions in the field of physical medicine and rehabilitation. For only the fourth and fifth times in AMA history, the House also approved special **citations to laymen** for outstanding service in advancing the ideals of medicine and contributing to the public welfare. Recipients of these awards were Mrs. Charles W. Sewell of Otterbein, Indiana, who has spent 45 years in rural health work, and Gobind Behari Lal, Ph. D., distinguished science writer and Pultizer prize winner.

Ohio's Delegation

The Ohio State Medical Association was represented in the House of Delegates by: Dr. Paul A. Davis, Akron; Dr. Charles L. Hudson, Cleveland; Dr. Carl A. Lincke, Carrollton; Dr. Paul F. Orr, Perrysburg; Dr. L. Howard Schriver, Cincinnati; Dr. C. C. Sherburne, Columbus; Dr. Herbert B. Wright, Cleveland, and Dr. George A. Woodhouse, Pleasant Hill, chairman of the delegation. Other Ohioans in the House of Delegates were: Dr. Charles L. Leedham, Cleveland, Section on Military Medicine, and Dr. Walter J. Zeiter, Cleveland, Section on Physical Medicine.

Dr. Schriver was chairman of the Reference Committee on Executive Session. Dr. Orr was a teller.

Dr. Woodhouse was reappointed by the President to the AMA Judicial Council.

Accompanying the delegates was Mr. Charles S. Nelson, Executive Secretary, and Mr. George H. Saville, director of public relations, of the OSMA. They also attended the Conference of Medical Society Executives held in San Francisco on the eve of the AMA Session.

Representing the U. S. Public Health Service in the House of Delegates was Dr. John D. Porterfield, well known in Ohio as former director of the Department of Mental Hygiene and Correction. He is now Deputy Surgeon General of the USPHS.

On behalf of the Ohio Delegation, Dr. Sherburne introduced a resolution on the subject of Voluntary Health Insurance for the Aged. This resolution was based on the action of the OSMA House of Delegates at the Cincinnati meeting, April 14-17, 1958, in adopting Resolution No. 2, introduced by Dr. C. R. Jablonski, Cleveland.

Resolution from Ohio

Dr. Sherburne's resolution, which was referred to the Reference Committee on Insurance and Medical Service, read as follows:

"Whereas, The rising cost of living has in many cases made it extremely difficult for the aged living on pensions or other fixed incomes to meet the costs of medical care; and

"Whereas, The problem is expected to worsen due to the rising number of aged in our population and due to the constant rise in costs of living; and

"Whereas, The many attempts to solve the problem in the Congress of the United States all would open the door to socialized medicine; and

"Whereas, The House of Delegates of the Ohio State Medical Association in session on April 17, 1958, expressed the belief that voluntary health insurance programs may be in a position to assist in meeting this problem; therefore be it

Resolved, That the newly-created Joint Council to Improve the Health Care of the Aged should take immediate steps to confer with voluntary health insuring agencies and organizations on the feasibility of offering a contract which will provide (1) medical and hospital coverage for those beyond the age of 65 and (2) a method whereby the insured may secure paid-up coverage for life through the payment of necessary premiums prior to attaining the age of 65 years."

Ohio Proposal Approved

The report of the reference committee on the resolution, which was unanimously approved by the House of Delegates, follows:

"**Your reference committee is in general agreement with the intent of this resolution.** It approves Section (1) of the resolution. Your committee, however, is of the opinion that the second section of the resolution concerning 'paid up coverage for life through the payment of necessary premiums prior to attaining the age of sixty-five years' may not now be considered feasible. This committee wishes to call your attention to the report of the Reference Committee on Insurance and Medical Service urging a continuation of studies along these lines which was approved by the House of Delegates at the 1957 Clinical Session. Further, your committee is of the opinion that it is inappropriate to refer resolutions from this House directly to an inter-association group such as the Joint Council to Improve the Health Care of the Aged. With these comments in mind the committee **recommends adoption of this resolution with the suggestion that it be referred to the Board of Trustees for proper implementation.**"

United Mine Workers

Major discussion of relations between medicine and the UMWA Welfare and Retirement Fund centered on a reference committee report which concurred in a Board of Trustees opinion that final action on two resolutions adopted in December, 1957, should be postponed until the final report of the Commission on Medical Care Plans is received.

One of those resolutions, Number 20, declared that "a broad educational program be instituted at once by the American Medical Association to inform the general public, including the beneficiaries of the Fund, concerning the benefits to be derived from preservation of the American right to freedom of choice of physicians and hospitals as well as observance of the 'Guides to Relationships Between State and County Medical Societies and the UMWA Welfare and Retirement Fund' adopted by this House last June."

The other resolution, Number 24, called for the appropriate AMA committee or council to engage in conferences with third parties to develop general principles and policies which may be applied to their relationships with members of the medical profession.

In explaining its position that final action on the two resolutions should be taken only after proper study, the reference committee said it "anticipates that the final report of the Commission on Medical Care Plans will contain recommendations serving to clarify the relationships between the medical profession, the patient and third parties, and the committee has been assured that this can be expected." The committee also urged the Commission to present its recommendations no later than December, 1958.

The House of Delegates, however, by a vote of 110 to 72, adopted a floor amendment "**that this section of the Reference Committee report be amended to show that our AMA Headquarters Staff is directed, under supervision of the Board of Trustees, to proceed *immediately* with the campaign which was originally ordered at Philadelphia last December, that no further delays will be tolerated, and that the Council on Medical Service be relieved of any further responsibility in this matter.**"

Social Security Coverage

In considering seven resolutions dealing with the inclusion of self-employed physicians under the Social Security Act, the House disapproved of three which called for polls or a referendum of the AMA membership, one which favored state-by-state participation in Social Security, and two which called for compulsory inclusion on a national basis.

Instead, the House adopted a resolution pointing out that "American physicians always have stood on the principle of security through personal initiative," and **reaffirming unequivocal opposition to the compulsory inclusion of self-employed physicians in the Social Security system.**

On the question of polls, the House expressed the opinion that any poll should be taken on a state-by-state basis and the results transmitted to the AMA delegates from that state. It also pointed out that since there is no provision in the Constitution and Bylaws for a referendum of members, such a referendum would usurp the duties and prerogatives of the House of Delegates, which is the Association's policy-making body.

Voluntary Health Organizations

Dealing with problems that have arisen in the raising and distributing of funds since development of the concept of united community effort, **the House adopted the following statement** offered in the form of amendments from the floor:

"1. That the House of Delegates reiterate its commendation and approval of the principal voluntary health agencies.

"2. That it is the firm belief of the American Medical Association that these agencies should be free to conduct their own programs of research, public and professional education and fund raising in their particular spheres of interest.

"3. That the House of Delegates respectfully requests that the American Medical Research Foundation take no action which would endanger the constructive activities of the national voluntary health agencies.

"4. That the Board of Trustees continue actively its studies of these perplexing problems looking forward to their ultimate solution."

Veterans' Medical Care

Pointing out that the Federal government spent $619,614,000 on hospitalized medical care of veterans in VA hospitals in 1957, of which about 75 per cent had non-service-connected disabilities, and that ways and means of obtaining economy in Federal government are allegedly being sought by Congress at this time, the House **urged Congressional action to restrict hospitalization of veterans at VA hospitals to those with service-connected disabilities.** It also recommended that the American Medical Association suggest to the Dean's Committees that they restrict their activities to Veterans Administration hospitals admitting only patients with service-connected disabilities.

The Medicare Program

In disapproving a resolution calling for repeal, modification or amendment of Public Law 569, the House took the position that desired changes in the Medicare program could be accomplished **through modification of the present implementing directives without the necessity for new legislation. The House reaffirmed the action taken last year in New York recommending that the decision on type of contract (service or indemnity) and whether or not a fee schedule is included in future contract negotiations should be left to individual state determination.** Also reaffirmed was the Association's basic contention that the Dependent Medical Care Act as enacted by Congress does not require fixed fee schedules; the establishment of such schedules would be more expensive than permitting physicians to charge their normal fees, and fixed fee schedules would ultimately disrupt the economics of medical practice.

Washington Office

The House adopted a resolution requesting the Board of Trustees to make an immediate **survey and re-evaluation of "the functions and effectiveness of the over-all AMA legislative system, including the Washington Office,** in the light of present-day needs of the government, public and medical profession alike for effective liaison between government and medicine on all matters affecting the public's health and adequate, prompt and accurate transmittal to the full membership of the AMA of information on all current public issues in which the physician has a direct interest." The House asked that the Board of Trustees implement, as rapidly as possible, all changes and additions that its survey discloses are desirable to achieve the basic purpose of the resolution, "effective public and government relations."

Medical Aspects of Hypnosis

A Council on Mental Health report on "Medical Use of Hypnosis" was approved by the House, which recommended that it be published in *The Journal of the American Medical Association* with bibliography attached. The report stated that general practitioners, medical specialists and dentists might find hypnosis valuable as a therapeutic adjunct within the specific field of their professional competence. It stressed, however, that all **those who use hypnosis need to be aware of the complex nature of the phenomena involved.** Teaching related to hypnosis should be under responsible medical or dental direction, the report emphasized, and should include the indications and limitations for its use. The report urged physicians and dentists to participate in high level research on hypnosis, and it vigorously condenmed the use of hypnosis for entertainment purposes.

Over-the-Counter Medications

The House endorsed recommendations by the Public Relations Department that:

The AMA join with other interested groups in setting up an expanded voluntary program, coordinated by the National Better Business Bureau, which will **seek to eliminate objectionable advertising of over-the-counter medicines.**

The AMA counsel with the National Better Business Bureau in the selection of a physicians' advisory committee.

The established facilities of the AMA, such as the Chemical Laboratory, the offices of the various scientific councils, and the Bureau of Investigation, be made available, so far as is feasible, to aid in the carrying out of this program.

The Public Relations Department continue its liaison work with the various groups involved and assist in the development and operation of this program in any way possible.

The AMA become a sustaining member of the National Better Business Bureau, giving evidence of its willingness and desire to support this organization in its worthwhile activities.

Miscellaneous Actions

Actions were taken on many other subjects by the House as follows:

Adopted amendments to the **Constitution and Bylaws** which eliminate the separate offices of Secretary and Treasurer, combining them into one, and which change the titles of the General Manager and Assistant General Manager to Executive Vice-President and Assistant Executive Vice-President;

Recommended the appointment of a Committee on **Atomic Medicine** and Ionizing Radiation and suggested that it concern itself with informing the American public on all phases of radiation hazards related to the national health;

Approved in principle the admission of the **Virgin Islands Medical Society** as a constituent society of the American Medical Association;

Commended the **Federal Food and Drug Administration** for its untiring efforts in behalf of the public and the profession, and urged all states to review and strengthen their food and drug laws;

Approved the "Suggested Guides for the Organization and Operation of Medical Society **Committees on Aging**," submitted by the Council on Medical Service;

Commended the Committee on Medical and Related Facilities of the Council on Medical Service for its report on the **Hill-Burton** Study and approved its recommendations;

Requested that any funds provided under the Public Assistance provisions of the Social Security Act for **medical care of the indigent** be administered by a voluntary agency such as Blue Shield on a cost plus basis or by a specific agency established by the medical society of the state in which indigent care is rendered;

Directed the Board of Trustees to study problems pertaining to licensure by **reciprocity** and to consult with the Federation of State Medical Boards in an attempt to find a satisfactory solution;

Urged all members of the House of Delegates to give full consideration to the preliminary report of the Committee on Preparation for **General Practice** and to submit comments and suggestions to that committee;

Expressed the opinion that some operating room experience is valuable and necessary training for all **nurses**:

Recommended that general hospitals, wherever feasible, be encouraged to permit the hospitalization of suitable **psychiatric patients**, and

Approved a **National Interprofessional Code** for physicians and attorneys prepared by the joint liaison committee of the American Medical Association and the American Bar Association.

Opening Session

At the Monday opening session Dr. David B. Allman, retiring AMA president, urged every physician to rededicate himself to the service of mankind and every medical society to strengthen its disciplinary system "to prevent the very few from besmirching the vast majority of us."

Inaugural Ceremony

Dr. Gundersen, in his inaugural address, called upon the medical profession to accept its full responsibilities in promoting better world health, brotherhood and peace, adding that "the time has come when medical statesmanship must be used to augment the methods of political diplomacy."

Election of Officers

In addition to Dr. Orr, the new president-elect, the following officers were elected by the House:

Dr. W. Linwood Ball of Richmond, Va., vice-president; Dr. E. Vincent Askey of Los Angeles, re-elected speaker, and Dr. Norman A. Welch of Boston, vice-speaker.

Dr. Warren W. Furey of Chicago was elected for a five year term on the Board of Trustees, succeeding Dr. E. S. Hamilton of Kankakee, Ill. Dr. Raymond M. McKeown of Coos Bay, Ore., was re-elected for a five year term, and Dr. R. B. Robins of Camden, Ark., was named to fill the unexpired term of Dr. F. J. L. Blasingame.

Dr. Leonard W. Larson of Bismarck, N. D., was elected chairman of the Board at its organizational meeting after the Thursday elections.

Elected to the Council on Medical Education and Hospitals were Dr. Leland S. McKittrick of Brookline, Mass., to succeed himself, and Dr. John V. Bowers of Madison, Wis., to succeed Dr. Victor Johnson of Rochester, Minn.

Dr. R. B. Chrisman, Jr., of Coral Gables, Fla., and Dr. J. F. Burton of Oklahoma City, Okla., were re-elected to the Council on Medical Service. For the same Council, Dr. Russell B. Roth of Erie, Pa., was named to fill the unexpired term of Dr. H. B. Mulholland of Charlottesville, Va., resigned.

Three members were elected to the Council on Constitution and Bylaws: Dr. William Stovall of Madison, Wis., to succeed Dr. Stanley H. Osborn of Hartford, Conn.; Dr. William Hyland of Grand Rapids, Mich., to fill the unexpired term of Dr. Floyd S. Winslow, deceased, of Rochester, N. Y., and Dr. Walter Bornemeier of Chicago, to replace Dr. Furey.

The House approved a Board of Trustees announcement that Miami Beach will replace Chicago as the place of the 1960 Annual Meeting. Atlantic City will be the site for the 1959 session and New York the 1961 meeting. Action was postponed on selection of the city for the 1962 Annual Meeting.

Rising votes of appreciation were given to Dr. Hamilton; Dr. George F. Lull, retiring secretary, and Dr. J. J. Moore, retiring treasurer.

At the Wednesday session of the House the Illinois State Medical Society made another record state society contribution to the American Medical Education Foundation by turning over a check for $177,500 to Dr. Lull, now foundation president.

* * *

Ohioans on the AMA Program . . .

In Addition to the Official Delegation of the OSMA, Many Physicians From This State Participated in the Program or Presented Exhibits

NEARLY a hundred physicians from Ohio were listed as participants in the Scientific Program or as exhibitors at the 1958 Annual Session of the American Medical Association in San Francisco, June 23-27, according to the official program published in *The Journal of the AMA.*

Scientific Program

Dr. Carl A. Lincke, Carrollton, member of the Council on Scientific Assembly, presided over a general scientific meeting panel discussion on the management of the severely injured patient.

Dr. Robert A. Hingson, professor of anesthesiology of Western Reserve, Cleveland, participated in the foregoing panel on management of the severely injured patient, discussing "Anesthetic Aspects."

Dr. Kenneth C. McCarthy, Toledo, chairman of the Section on Anesthesiology, presented the Chairman's Address before a meeting of that section on the topic "The Problem of Cardiac Arrest."

Dr. Jay Jacoby, Columbus, participated in a discussion on "Complications of Endotracheal Intubation," before the Section on Anesthesiology on Thursday afternoon.

Dr. Donald J. Birmingham, Cincinnati, opened discussion on a paper, "Value of Patch Tests in Dermatologic Diagnosis with Special Study of Follicular Reactions," before the Section on Dermatology on Wednesday afternoon.

Drs. W. J. Kolff and W. A. Keleman, Cleveland, are co-authors of a paper, "The Present Status of the use of Artificial Kidneys in Relation to Other Methods" presented as a part of a symposium on the Clinical Application of the Artificial Kidney before the Section on Experimental Medicine and Therapeutics on Thursday morning.

Dr. Rupert B. Turnbull, Jr., of Cleveland, spoke on the topic, "Present-Day Experience with the Surgical Management of Chronic Ulcerative Colitis," before the Section on Gastroenterology and Proctology on Tuesday afternoon.

Dr. George S. Hackett, Canton, presented a paper before the Section on General Practice, Thursday morning, on the subject, "Cervical Whiplash Injury."

A team from Cleveland, Drs. Fay A. LeFevre, Alfred W. Humphries and Victor G. deWolfe, presented the subject, "The Management of Arteriosclerosis Obliterans of the Extremities," before the Section on Internal Medicine on Tuesday afternoon.

Dr. Alvin Davis, Cincinnati, participated in a panel discussion on the subject, "Noise—Is It a Health Problem?" before the Section on Laryngology, Otology and Rhinology on Wednesday morning.

Additional Speakers

Dr. Charles L. Leedham, Cleveland, in addition to being delegate of the Section, opened discussion on a paper entitled "Renal Residuals of Acute Hemorrhagic Fever — Three-to-Five-Year Follow-Up," before the Military Section.

Dr. Robert T. P. deTreville, Dayton, opened discussion on a paper entitled, "Microwave Effects—A Report on the Progress of the Air Force Program Investigating the Biological Effects of Electromagnetic Radiation," before the Section on Military Medicine on Thursday morning.

A team from Dayton—Drs. Edwin Z. Levy, G. E. Ruff, and V. H. Thaler, presented a paper before the Section on Military Medicine on Friday morning, the title of which was "Studies in Human Isolation and Crew Confinement."

Dr. John M. Painter, Kent, spoke on the subject, "A Holistic Approach to Clinical Problems of Hypersensitivity," before a Session on Allergy on Friday morning.

Drs. James S. Krieger and Lawrence J. McCormack, Cleveland, are co-authors of a paper entitled "The Individualization of the Therapy of Carcinoma In Situ of the Cervix—A Program," presented before the Section on Obstetrics and Gynecology.

Discussions on the Eye

Dr. Donald J. Lyle, Cincinnati, opened discussion on a paper entitled "Ocular Signs and Prognosis in Subdural and Subarachnoid Bleeding in Young Children," before the Section on Ophthalmology on Tuesday afternoon.

Drs. Nick Sperelakis and Albert M. Potts, Cleveland, presented a paper entitled, "Additional Observations on Lenticular Potentials," before the Association for Research in Ophthalmology on Tuesday morning.

Drs. Albert M. Potts and Beatrice Cohen, Cleveland, are authors of a study entitled, "The Transfer of Corneal Water as Measured with the Aid of Tritium Oxide," presented before the Association for Research in Ophthalmology on Tuesday morning.

Drs. Sam G. Stubbins and W. H. McGaw, Cleveland, are co-authors of a paper on the subject, "Hanging Cast Treatment of Acromioclavicular Separations and Selected Clavicular Fractures," presented before the Section on Orthopedic Surgery on Tuesday afternoon.

Dr. Joseph E. Brown, Cleveland, opened a discussion on a paper entitled "The Orthopedic Management of Neuropathic Joints," presented before the Section on Orthopedic Surgery on Wednesday afternoon.

Dr. James I. Kendrick, Cleveland, opened discussion on a paper, "Internal Fixation of the Fibula in Fractures of Both Bones of the Leg," before the Section on Orthopedic Surgery on Thursday afternoon.

Dr. Paul A. Nelson, of Cleveland, spoke on "Physical Treatment of the Painful Arm and Shoulder," before a joint meeting of the Section on Orthopedic Surgery and the Section on Physical Medicine on Friday morning.

Dr. Ernest W. Johnson and Dr. Karl J. Olsen, Columbus, presented a discussion of the subject, "Examination for Muscle Weakness in Infants and Small Children," before the Section on Physical Medicine.

Drs. Claude S. Beck, David S. Leighninger, Jess Bond and Bernard Brofman, Cleveland, are sponsors of a paper on the subject, "Coronary Artery Disease—Some New Concepts: Results Following Surgical Operation," presented before the Section on Surgery, General and Abdominal on Thursday morning.

Dr. A. W. Humphries, of Cleveland, presided at the showing of a motion picture "Techniques of Angiography," to be shown in a repeating series Monday through Friday.

Dr. Robert S. Green, of Cincinnati, presided at the showing of a motion picture, "Cinefluorography of the Heart and Lungs.

The Scientific Exhibit

Dr. Ralph G. Carothers, Cincinnati, was chairman of the Special Exhibit on Fractures, presented in a series of demonstrations.

The following Ohio physicians participated in the Special Exhibit on Fractures as demonstrators: Drs. L. J. Cordrey, Cleveland; F. Paul Duffy, Cincinnati; R. T. Gallagher, Cincinnati; Nicholas J. Giannestras, Cincinnati, and John C. Schmerge, Cincinnati.

The following Ohio physicians participated in the Special Exhibit on Pulmonary Function as demonstrators: Drs. Frank Princi, Cincinnati; J. F. Tomashefski, Columbus; H. S. Van Ordstrand, Cleveland, and George Wright, Cleveland.

Dr. W. Clark Cooper, Cincinnati, represented the U. S. Public Health Service at the "lung station" exhibit.

Dr. J. F. Tomashefski, Columbus, was one of the demonstrators in the special "lung station" exhibit.

A team from the Ohio Tuberculosis Hospital, Ohio State University—Drs. Neil C. Andrews, A. J. Christoforidis and Philip C. Pratt, presented the exhibit, "Bronchogenic Cysts in Patients Presumed To Have Pulmonary Tuberculosis," in the Section on Diseases of the Chest.

Dr. George S. Hackett, Canton, presented the exhibit, "Occipitocervical and Low Back Pain," in the Section on General Practice.

Dr. William F. Bradley, Columbus, Central Ohio Foundation for Medical Education and Research, presented the exhibit, "Clinical Experiences with Triiodothyronine," in the Section on Internal Medicine.

Drs. Penn G. Skillern, Marvin Clamen, E. Perry McCullagh and Otto Glassner, Cleveland Clinic, Cleveland, presented the exhibit, "Radioiodine for Diagnosis and Therapy of Hyperthyroidism Due to Adenomatous Goiter," in the Section on Internal Medicine.

Dr. Curtis G. Park, Aero Medical Laboratory, Wright-Patterson Air Force Base, Dayton, presented an exhibit entitled "Men and Space," in the Section on Military Medicine.

Drs. James S. Krieger and Lawrence J. McCormack, Cleveland Clinic, presented the exhibit "Cervical Carcinoma In Situ: The Role of Radical Conization," in the Section on Obstetrics and Gynecology.

Drs. Lee J. Cordrey and James H. Christie, Highland View Hospital and Western Reserve University School of Medicine, Cleveland, presented the exhibit, "Analysis and Management of Paraosteoarthropathy in Neurologic Disease," in the section on Orthopedic Surgery.

Ohio Auxiliary a Winner In Today's Health Contest

The Woman's Auxiliary to the Ohio State Medical Association carried off one of the top honors at the Woman's Auxiliary meeting held in connection with the 1958 AMA meeting in San Francisco.

It was a winner in Group 4 (membership over 3,000) for the most subscriptions to *Today's Health.*

Among the County Auxiliary winners, the Clark County Medical Society Auxiliary took second place in Group 3 (membership from 76 to 150).

Dr. F. W. Rhinelander, Cuyahoga County Hospital and City Hospital, Cleveland, presented an exhibit, "Internal Fixation of Bone Fragments with Flexible Wire and Pins," in the section on Orthopedic Surgery.

Dr. J. W. Wilce, Ohio State University College of Medicine, Columbus, presented the exhibit, "Improved Cardiac Guidance for Sport: Backgrounds and Practical Suggestions," in the Section on Preventive Medicine.

Drs. Thomas F. Meaney and Charles R. Hughes, Cleveland Clinic, presented an exhibit entitled "Segmental Motor Paralysis: A Cause of Intestinal Obstruction and Ileostomy Disfunction," in the Section on Radiology.

Drs. William Molnar, Sidney W. Nelson, Karl P. Klassen and Joseph A. Ryan, University Hospital, Columbus, presented the exhibit "Aortic Valvulography and Ascending Aortography," in the Section on Radiology.

Drs. W. A. Hawk and A. W. Humphries, Cleveland Clinic, presented the exhibit, "Clinicopathological Observations on the Fate of Arterial Freeze-Dried Homografts," in the Section on Surgery, General and Abdominal.

Drs. Paul J. Stueber, Jr., Stevens Kovacs, Simon Koletsky, and Lester Persky, Western Reserve University School of Medicine and University Hospitals, Cleveland, presented an exhibit entitled, "Regional Renal Hypothermia," in the Section on Urology.

Dr. Raymond C. Pogge, Cincinnati, was cosponsor of an exhibit on "Medical Careers," promoted by the Medical Section of the American Drug Manufacturers Association, in the Section on Miscellaneous Topics.

Obstetricians and Gynecologists To Meet at French Lick

District V of The American College of Obstetricians and Gynecologists will meet in French Lick, Indiana on September 25, 26, and 27. The states comprising this District are: Indiana, Kentucky, Michigan, Ohio; and the Province of Ontario, Canada. Physicians of these states and province are invited to attend the scientific and social functions of the meeting. Additional information may be obtained by writing Arthur G. King, M. D., 199 William Howard Taft Road, Cincinnati 19, Ohio, District Chairman, or Sprague H. Gardiner, M. D., 23 East Ohio Street, Indianapolis 4, Indiana, general program chairman.

Registration will officially start at 8:00 a.m. Friday.

Dr. E. H. Ellison Leaves Columbus To Accept Marquette Post

Dr. Edwin H. Ellison, professor and executive officer of the Ohio State University Department of Surgery, has accepted appointment as chairman of the Department of Surgery at Marquette University School of Medicine in Milwaukee. He was a member of the Ohio State Medical Association Committee on Scientific and Educational Exhibits. He has also served as a member and chairman of the OSMA Section on Surgery.

A native of Columbus and graduate of the OSU College of Medicine, 1943, he has been associated with the college since. Dr. Ellison is author of about 50 professional papers and one surgical text. In association with Dr. Robert Zollinger, chairman of the OSU Department of Surgery, he made valuable contributions in such fields as the relationship between tumors of the pancreas and intractable ulcers, the relationship between endocrine diseases and ulcers, causes of clots in surgical patients, etc.

Dr. Ellison was named man of the year by last year's senior class at OSU and won an American College of Surgeons award for his film on a method of removing the adrenal gland.

New VA Fee Schedule . . .

Put into Effect July 1 Following Conference With OSMA Officials; Old Contract Concluded but Little Change in Standing Procedure To Occur

A NEW medical and surgical fee schedule applying to the "Home Town" Veterans Administration medical program in Ohio became effective July 1. Increases were made in 149 items.

At the same time, the formal contract between the VA and the Ohio State Medical Association which had been in effect since July 1, 1946, was concluded by mutual agreement.

From now on the OSMA will not be required to carry on any clerical or administrative duties for the VA. It will serve in an advisory capacity. Also, it will confer from time to time with VA officials regarding desirable changes in the fee schedule.

Little Change in Procedure

Physicians, as in the past, will continue to deal with the VA Regional Office, Cleveland, or the Cincinnati VA Hospital, for authorizations and payment of fees.

Recently an inquiry was sent by the VA to physicians who were listed as participants but actually did not treat any veteran patients within the last few years. This questionnaire was to establish a more realistic roster and to determine eligibility for specialistic fees.

Any licensed physician in Ohio who is not on the VA participating list may ask to become a participant by applying individually to the VA. U. S. citizenship is a requirement.

Applications from physicians in northern Ohio should be sent to the Cleveland VA Regional Office; applications from physicians in southern Ohio, to the Veterans Administration Hospital, Cincinnati, Ohio. The dividing line by counties is roughly diagonally Belmont County on the East, to Paulding County on the west. Thirty-eight counties in northern Ohio are serviced by the Cleveland regional office; 50 counties in southern Ohio, by Cincinnati VA Hospital.

Rules Reviewed

The Fee Schedule lists many items which are hospital procedures and are rarely authorized by the VA regional offices, as care in a private hospital can only be authorized if the condition is service-connected, emergent, and if it would be hazardous to move the patient to a VA Hospital. Emergencies must be reported to the VA within 72 hours.

Outpatient treatment can not be granted for non-service-connected disabilities. The only exceptions involve Spanish American War veterans and some disabled veterans receiving vocational training. Request for care on an adjunct basis can be considered.

Prior authority should be obtained before starting treatment; however, if the condition is emergent and the care is urgently needed, there is a 15 day leeway.

New Forms

All regional VA offices are now using a new authority: VA Form 10-2989b (green) for long term, and a separate VA Form 10-2989a (white) for short term authorities. Code sheets are prepared and all data for reports, professional, statistical and fiscal, are obtained from IBM cards. A separate billing is expected at the end of each calendar month on the physician's own stationery for each VA patient. Reports of treatment rendered are required monthly on all short term cases, but only quarterly in regard to long term authorities. It is hoped that the new procedures will be advantageous and time saving for the participating physicians and the VA.

Physicians who did not receive a new fee schedule from the VA and desire one should write to either the Cleveland or Cincinnati VA offices. The new fee schedule was worked out at conferences between Dr. H. P. Timberlake, chief medical officer of the Cleveland Regional Office, and officials of the Ohio State Medical Association.

Some New Fees Listed

It would not be practical for *The Journal* to publish the entire new fee schedule. Following are a few items, picked at random from the fee schedule, exclusive of major surgical fees inasmuch as most of the VA surgery is done in VA hospitals:

Visits and Examinations

0005—Complete general routine physical examination including routine urinalysis (chemical)—this item may be authorized for first office visit or first home visit when applicable	$10.00
0010—Detention with patient in critical condition at home or hospital, per hour (day 8 a.m. to 7 p.m.)	10.00

(Continued on Page 1074)

0015—Detention with patient in critical condition at home or hospital, per hour (night 7 p.m. to 8 a.m.)	15.00
0020—Examination to determine need for aid and attendance, in home	8.50
0025—Examination to determine need for aid and attendance, in office	7.50
0030—Examination to determine need for hospitalization, in home (day 8 a.m. to 7 p.m.)	5.00
0035—Examination to determine need of hospitalization, in home (night 7 p.m. to 8 a.m.)	8.00
0040—Examination to determine need of hospitalization, in office	4.00
0045—Home visit (day 8 a.m. to 7 p.m.)	5.00
0050—Home visit (night 7 p.m. to 8 a.m.)	8.00
0055—Hospital visit (day 8 a.m. to 7 p.m.)	5.00
0060—Hospital visit (night 7 p.m. to 8 a.m.)	8.00
0065—Mileage one way for day or night visit outside city limits (in addition to appropriate fee)	.75
0070—Office visit	4.00

Examinations by Specialists

0090—Cardiac examination including electrocardiogram	15.00
0095—Dermatological	10.00
0100—Ear examination with audiogram and interpretation	15.00
0115—Electrocardiogram with interpretation	10.00
0120—Electroencephalography with interpretation	25.00
0125—Examination of ears, nose and throat	7.50
0130—Examination of eyes with refraction, manifest or cycloplegic, to include either a copy of the prescription ordered or a report of the refractive error and fundus findings, as well as a report of abnormalities found	15.00
0135—Examination of eyes with refraction, manifest or cycloplegic, to include either a copy of the prescription ordered or a report of the refractive error and fundus findings, together with a report of the *visual field* findings (the latter by chart if the field is abnormal)	20.00
0180—Orthopedic	10.00
0185—Physical examination of lungs	10.00

Outpatient Treatment by Specialists

0200—Dermatological: First visit or home visit	7.00
0205—Dermatological: Each subsequent office visit	5.00
0210—Ear, nose and throat: First visit or home visit	7.00
0215—Ear, nose and throat: Each subsequent office visit	5.00
0220—Neurologic treatment	10.00
0225—Ophthalmological: First visit or home visit	7.00
0230—Ophthalmological: Each subsequent office visit	5.00
0235—Psychiatric treatment, one half-hour or less	7.50
0240—Psychiatric treatment, period longer than one half-hour	15.00
0245—Other comparable specialities not listed above: First visit or home visit	7.00
0250—Other comparable specialities not listed above: Each subsequent office visit	5.00

Physical Therapy

0325—Any combination of treatment to one extremity or back	3.50
0330—Any combination of treatment to two or more extremities and back	5.00
0335—Physical therapy treatment in home	5.00

Other Medical Services

0705—Injections: Subcutaneous, intramuscular or intravenous exclusive of cost of drug, biological or other medication	3.50
0707—Injection of joint, exclusive of cost of drug or other medication	6.00
0730—Nonsurgical drainage of gallbladder	10.00
1475—Varicose veins, injection	5.00
1735—Urethral dilation	10.00
2425—Corneal ulcer, cauterization	5.00
2515—Lacrymal duct, dilatation of	5.00
2885—Dislocation, shoulder, recurrent or habitual, reduction only	10-15 AA
3315—Sequestrum, removal of (superficial)	15-50 AA
3435—Paracentesis, tympanum	10.00
3515—Proctoscopy	10.00
3520—Sigmoidoscopy	10.00
3695—Pneumoperitoneum, artificial, refill	10.00

3705—Pneumothorax, artificial, refill with fluoroscopy	10.00
3800—Cyst, superficial, aspiration	10.00
3805—Tumor, superficial—fulguration or electrocoagulation	10.00

Removal, Excision, Resection

3820—Abscess	5-100 AA
3825—Cyst or tumor, small, benign	50.00
3835—Cyst, sebaceous	10-25 AA
3860—Papilloma, external	10.00

Unclassified

3900—Adenectomy, cervical or inguinal	15-150 AA
3905—Carbuncle	25-50 AA
3910—Cellulitis	25.00
3920—Ingrown toenail	15.00
3950—Foreign body removal	10-50 AA

Radiology

4000—Abdomen (KUB)	10.00
4005—Colon, barium enema	20.00
4020—Gallbladder, Graham technique	20.00
4025—Gastrointestinal, including barium meal and enema, X-ray and fluoroscopy with preliminary KUB film	35.00
4030—Pyelography, intravenous, including cost of dye	20.00
4215—Chest, AP and lateral	10.00
4225—Fluoroscopy when required without film	5.00
4230—Fluoroscopy when required in connection with a general examination	2.50
4435—Spine, entire	35.00
4700—Deep X-ray therapy per treatment, one field	10.00
4705—Deep X-ray therapy per treatment, two or more fields	20.00
4720—Superficial therapy, benign lesion, per treatment, one to three fields	5.00
4725—Superficial therapy, benign lesion, per treatment, more than three fields	10.00
4730—Superficial therapy for skin cancer, per treatment	15.00
4735—Superficial therapy for skin cancer, maximum fee for series	50.00

Pathology

5240—Blood platelet count	3.00
5255—Bromsulfalein test	4.00
5285—Coagulation time	1.00
5290—Complement - fixation tests for syphilis	3.50
5300—Dextrose	3.00
5305—Differential leucocyte count	2.00
5315—Estimation of sugar tolerance	10.00
5355—Nonprotein nitrogen	3.00
5380—Red, white and differential blood counts including instrumental colorimetric hemoglobin estimation	5.00
5390—Sedimentation rate	2.00
5410—Total erythrocyte count	2.00
5415—Total leucocyte count	2.00
5430—Urea nitrogen	3.00
5950—Urinalysis, routine chemical	1.00
5955—Urinalysis, routine chemical and microscopic	2.00

The designation "AA" represents a range of fees for a specific procedure. The proper fee for "AA" procedures will be determined in the exercise of sound professional judgment by arbitration and agreement between VA officials authorized to approve fees and the physician rendering the service.

Cleveland and Dayton Medical Societies Increase Their Executive Staffs

Two of Ohio's County Medical Societies have added associate or assistant executive secretaries to their staffs.

Mr. Kenneth C. Evans is the new associate executive secretary of the Montgomery County Medical Society. He is working with the executive secretary, Mr. Robert F. Freeman, in administration of the Society affairs as well as those of affiliated and allied organizations. These organizations, management of which the Society council has delegated to the staff include the MCMS Telephone Service, the Medical Foundation, Inc., the Central Homograft Unit, Inc., and the Bureau of Medical Economics, Inc. The staff also has responsibilities in regard to the local cancer control society and the local heart association.

Mr. Evans came to the Society after four years as business manager of the Westminster Presbyterian Church. Prior to that he was with the Frigidaire Expense Control Section. He received his training in business administration at Ohio State and served as captain in the Army during World War II.

The new assistant executive secretary for the Academy of Medicine of Cleveland and Cuyahoga County is Mr. Donald W. Mortimer. He will work with Executive Secretary Robert A. Lang in the administrative responsibilities of the Academy and its affiliate programs.

Mr. Mortimer is a graduate of Allegheny College, Meadville, Pa., and has recently earned a master's degree. For four years before accepting the Academy post he was assistant to the dean of Cleveland College of Western Reserve University and prior to that worked with the Warner & Swasey Executive Development Program. During World War II he served with the U. S. Air Force.

Are You Eligible To Vote? . . .

Between Now and September 24 Is the Time To Register for Those Who Want to Become Eligible To Vote in the November 4 General Election

IN the busy life of a physician and members of his family time passes quickly. The all-important General Election is November 4. An equally important date for those who must register before they can vote is September 24—last day to register.

Registration is a simple matter. Here are the points to be remembered, presented in question and answer form from information furnished *The Journal* by Secretary of State Ted W. Brown:

What is the registration deadline?

Forty days before the General Election, or September 24.

Who must register?

Every citizen who resides in a "registration district" must be registered with his county Board of Elections before he is eligible to vote.

What is a registration district?

The county Board of Elections must maintain a registration of eligible voters in every city of 16,000 population or over. Municipalities of less than 16,000 population may elect to maintain registration. The Board of Elections of a county may require registration in the entire county or in certain precincts. A registration district, therefore, may be a county, a municipality, a group of precincts or a single precinct.

How does a person know whether he is in a registration district or in a non-registration area?

If he resides in a municipality of 16,000 population or over, he must be registered. If he resides in a suburban community, a small municipality or a rural area, and is in doubt, he should phone the county Board of Elections and ask.

Under what conditions must a person re-register?

Registration is permanent, subject to the following exceptions:

a. If the citizen has not voted in a general, primary or special election since January 1, 1956, he must register again.

b. If the citizen has changed name—e. g., if a woman has married—she must re-register. If a woman marries between September 24 and November 4 she may vote on November 4 under her former name.

c. A veteran of the armed services must register after he is discharged.

d. A voter who changes his place of residence from one county to another, must register with the Board in the county to which he moves if his new residence is in a registration precinct. A voter who changes his residence to a new address within a registration district must notify his Board of Elections of such change. Some boards require the voter to present himself in person; others accept written notice.

What is the procedure for voters in non-registration areas?

In precincts not in registration districts, citizens are automatically eligible to vote. A voter may be required at the polling booth to produce evidence to the satisfaction of the election judge, or under oath, that he is qualified to vote.

What is the residence requirement for registration?

A person who will have met the residence requirement for voting by November 4—that is, will have lived in the State one year, in the county and precinct 40 days, and is otherwise qualified to vote—may register on or before September 24.

If he has moved his residence between September 24 and Election Day, what can he do?

Vote at the precinct from which he moved.

If a citizen has moved or is planning to move prior to September 24, may he vote at the precinct in which he formerly resided?

No. If he does not qualify himself to vote in the new precinct by notifying the Board of change of address, he will have lost his privilege of voting on November 4.

Suppose he moves his residence on September 23?

He will have been in the new precinct for 40 days by Election Day and, therefore, may register immediately.

If a citizen in a registration district will reach his 21st birthday between September 24 and November 4, may he register?

Yes. He may register on or before September 24.

If a person who resides in a non-registration

area will be 21 years old on or before November 4, what is the procedure?

If he meets other requirements of a voter, he will automatically become eligible to vote.

Where does one register?

At the headquarters of the Board of Elections of county of residence or at polling places indicated by the Board.

Where does a student register?

Ordinarily in the county in which he maintained residence just prior to entering the institution of learning.

How does a disabled person register?

A voter who is prevented by sickness or physical disability from registering in person may apply to his county Board of Elections by mail or phone for registration forms. The application must state the facts as to the voter's disability. Both the registration forms and a declaration of the facts as to disability must be notarized, and both must be delivered to the Board of Elections by a reliable and responsible person. Some boards require this person to be a notary public.

What about persons in the armed forces?

Persons who are residents of a registration district and who are in active service in the armed forces, and are otherwise qualified to vote, may cast absentee ballots without previous registration.

Does this privilege extend to civilians who will be away from home on November 4?

No. Students and other persons who must be registered in order to vote and who plan to be away on November 4, should register now so that they will be eligible to cast absentee ballots.

ABSENTEE VOTING

Persons who will be away from home on November 4 should plan to cast absentee votes. Here are some dates to remember and other data on absentee voting:

Civilians who wish to cast absentee ballots must be qualified to vote the same as though they were voting at home; e. g., they must be registered if they live within a registration area.

Civilians must apply for ballots on forms furnished by election boards. Upon receipt of filled out applications, boards will mail ballots which are to be properly filled out and returned in accompanying "identification" envelopes.

Ohioans who will be more than 10 miles from their polling places and outside their home counties on election day are eligible for absentee voter ballots.

September 5—First day for civilians outside the continental limits of the United States, such as wives of military men, to apply for absent voter ballots.

September 24—Last day for persons who must register in order to qualify for voting, to register with their local Board of Elections.

October 5—First day for absent and disabled voters within the United States to apply for ballots.

October 30—Last day for "absent or disabled" civilians to apply. The deadline is 4 p. m.

October 31—Last day for civilians to return voted ballots to election boards to have them count. The deadline is noon of that day. Military personnel have until noon of election day, November 4.

November 1—Last day for members of the armed services to apply for ballots. Their deadline is 12 noon. Military service personnel have been eligible to apply for ballots since January 1.

Industrial Medical Program To Be Conducted in Akron, Sept. 19

The Industrial Medical Association of Pittsburgh, a component society of The Industrial Medical Association, will present a program on Friday, September 19 at the Sheraton Hotel, in Akron.

9:00 A. M.—Registration—*Promptor Finis Fui.*
9:30—Greetings by Dr. Arthur Dobkin, president of the Summit County Medical Society. Remarks by Dr. Don A. Kelly, Cleveland, president of the Industrial Medical Association of Pittsburgh.
9:45—**The Use of the Artificial Kidney in Poison Cases,** Dr. Walter A. Keitzer, Akron.
10:15—**Lung Surgery as Related to Occupational Conditions,** Dr. William H. Falor, Akron.
10:45—Recess.
11:00—**Reconstructive Surgery in Industry,** Dr. E. J. Kraker, Akron.
11:30—**Rehabilitation of Industrial Workers,** Dr. K. C. Keeler, Akron.
12:00 M—Luncheon and showing of the film, "Medicine in the Tropics."
1:30 P. M.—**Panel,** Moderator, Dr. Paul A. Davis, Akron.

1. **Health Hazards in the Rubber Industry, Yesterday and Today,** Dr. Warren L. Hogue, Jr., Akron.
2. **Toxicology of Materials Used in the Rubber Industry,** Dr. Rex H. Wilson, Akron.
3. **Relationship of Industrial and Private Practice,** Dr. L. C. Hatch, Akron.

3:40—Business Meeting.
4:00—Cocktail Party.

Medical Board Examinations . . .

Total of 417 Graduates of Schools of Medicine Apply for Licenses in State; List of Questions Is Given; Limited Practitioners Also Apply

THE State Medical Board of Ohio examined 417 graduates of schools of medicine who are seeking licenses to practice in the state during its examinations in Columbus June 19-21, Dr. H. M. Platter, Board secretary, reported. The board also examined 50 graduates of osteopathic schools who are seeking to practice osteopathic medicine and surgery in Ohio.

In the limited practice fields the board examined the following numbers of persons: Chiropody, 17; mechanotherapists, 10; chiropractors, 44; masseurs, 21; cosmetic therapists, 4.

Results of the examinations will be announced following a meeting of the board on August 18.

Following are the examination questions given to doctors of medicine:

Anatomy

1. In words, or by diagram (labelled), give a description of a hair follicle.
2. Name the muscles of the orbit.
3. Locate the following: (a) bregma, (b) glabella, (c) nasion, (d) inion, (e) lambda.
4. Describe an eustachian tube.
5. Give a description of the arterial and venous circulation of the kidney.
6. Enumerate the divisions of the large intestine, stating approximate length of each portion.
7. In doing a tracheotomy, what structures are involved?
8. Describe the thoracic duct.
9. Name the ligaments of the ankle joint, giving function of each.
10. Describe the prostate gland and its anatomical relationships.

Physiology

1. Name and describe briefly the several retinal functions upon which the acuteness of vision depends.
2. Discuss briefly olfaction as to: (a) Location of olfactory area; (b) As to the nature of the olfactory stimulus.
3. Discuss histamine as to: (a) its concentration in human blood; (b) its effect on human blood vessels; (c) on blood pressure; (d) on gastric juice.
4. Explain the morning alkaline tide of the urine.
5. Name and discuss briefly the placental hormones.
6. Explain the physiology of cardiospasm.
7. Explain the physiology of motion sickness.
8. Discuss briefly the mechanism of the action of insulin on: (a) Glycogen storage; (b) Fat metabolism; (c) Protein metabolism; (d) Oxidation of sugar.
9. Discuss the physiology of hypoglycemia.
10. Discuss extrasystoles as to: (a) Ventricular, (b) Auricular, (c) Nodal.

Bacteriology

1. In a patient with negative history and physical findings, what is the significance of a weakly reactive sero-diagnostic test for syphilis, and how would you proceed?
2. Discuss the significance of pathogenic staphylococci in the feces.
3. Discuss the significance of coliform bacteria in water.
4. How would you proceed in attempting to identify the cause of a virus infection?
5. In what areas and under what circumstances is moniliasis apt to occur?

Diagnosis

1. List five cardinal diagnostic findings which suggest a diagnosis of Multiple Myeloma.
2. Differentiate "Mediterranean Anemia" from: (a) Gauchers Disease; (b) Niemann-Pick Disease; (c) Schuller-Christian's Syndrome.
3. Differentiate Celiac Disease and Tropical Sprue.
4. In general terms, the urinary and blood findings or changes of acute nephrosis are similar to those observed in acute glomerulonephritis except that:
   (a) Hematuria is less frequent: —Yes. —No.
   (b) Albuminuria is more marked: —Yes. —No.
   (c) Hypoproteinemia with consequent edema is more pronounced: —Yes. —No.
   (d) Nitrogen retention is less severe or entirely absent: —Yes. —No.
   (e) Reduction in blood calcium is less marked: —Yes. —No.
5. A male patient of 35 years of age reveals a history of shortness of breath, edema or swelling of the ankles. Physical examination reveals the following:

   1. Harsh systolic murmur. Best heard at the second or third left intercostal space.
   2. Also, the murmur is heard in the left clavicular region.
   3. A palpable systolic thrill in the second or third left interspace.
   4. A decrease in the intensity of the second heart sound at the pulmonic area.
   5. X-ray findings reveal a heart within normal limits of size.
   6. Electrocardiogram reveals right ventricular strain pattern. The P waves are large with abnormally pointed peaks.
   7. Cardiac catheterization reveals an increase in systolic pressure recorded as the catheter is withdrawn from the pulmonary artery into the right ventricle.

   The diagnosis of the impairment is:
   (a) Left ventricular failure: —Yes. —No.
   (b) Rheumatic Valvulitis: —Yes. —No.
   (c) Tetralogy of Fallot: —Yes. —No.
   (d) Congenital Septal Defect: —Yes. —No.
   (e) Pulmonary stenosis: —Yes. —No.
6. Differentiate on basis of symptoms: (a) Cholelithiasis, (b) Nephrolithiasis, (c) Appendicitis, (d) Peptic Ulcer, (e) Coronary Thrombosis (Myocardial infarction).
7. Differentiate between carbon monoxide poisoning and carbon tetrachloride poisoning on basis of symptoms and findings.
8. Name three diagnostic factors that differentiate Weil's Disease from acute pyogenic and viral infections.
9. In every obscure infection in which there is enlargement of the lymph nodes with or without ac-

companying enlargement of the liver and spleen, one should suspect:
   (a) Tularemia: —Yes. —No.
   (b) Brucellosis: —Yes. —No.
   (c) Histoplasmosis: —Yes. —No.
   (d) Typhoid Fever: —Yes. —No.
   (e) Mononucleosis: —Yes. —No.

10. Name one characteristic diagnostic procedure which will differentially diagnose: (a) Tularemia, (b) Brucellosis, (c) Histoplasmosis, (d) Typhoid Fever, (e) Mononucleosis.

Chemistry

1. Outline the indications for gastric analysis. In what way is it valuable as a screening diagnostic procedure?
2. Give the normal range of serum albumin concentration (plasma). Give the range found in: (a) Nephrotic syndrome; (b) Advanced cirrhosis.
3. Discuss the metabolism of Bilirubin. Discuss the Van Den Bergh reaction for Bilirubin.
4. Outline the means by which glucose is removed from the circulating blood.
5. Discuss amino acids. Where are they found? What are essential amino acids and state why they are essential.

Materia Medica and Therapeutics

1. Give the duties of the physician in case of poisoning.
2. Compare the effects of cortisone and corticotropin on the adrenal cortex.
3. Give the mechanisms of action of the anti-thyroid (goitrogenic) drugs.
4. Give the treatment of hypertonicity of body fluids caused from: (a) Solute loading; (b) Desiccation or true hydration.
5. Give the action of morphine 10 mg. (1/6 Grain) upon the central nervous system.
   (b) Give the fate of morphine in the body.
6. Make a table contrasting the action of digitalis and quinidine upon tonus, contraction, refractory phase, conduction and volume output of the heart.
7. Give the onset, peak action and duration of soluble unmodified insulin, globin, isophane and protamine zinc insulin.
8. Give the treatment of hemorrhage from Bishydroxy coumarin (dicumarol).
9. Outline treatment of delirium tremens.
10. Give the treatment of diphtheria.

Practice

1. Define Erythremia (Polycythemia rubra).
   (a) Give three symptoms.
   (b) Name five objective findings other than the blood count.
   (c) Give the blood findings: (1) Red blood count; (2) Leucocyte count; (3) Platelet count; (4) Bleeding time and coagulation time; (5) Hemoglobin determination.
2. What is the treatment of choice in managing a case of erythremia (Polycythemia vera or Polycythemia rubra)?
3. Define Diphtheria (giving etiology). (a) Give the treatment, and (b) Prophylaxis; (c) Complications.
4. What is the etiology of syphilis? (a) Mode of transmission; (b) Give briefly the treatment.
5. What is meant by the term "Collagen Disease"? Name three collagen diseases.
6. Differentiate between (a) Heat exhaustion; (b) Heat stroke; (c) Heat cramps.
   (a) Elicit the treatment for each.
   (b) Prophylaxis.
7. Enumerate five objective findings in Thyrotoxicosis (Hyperthyroidism). (a) Describe the treatment.
8. Differentiate between Diverticulosis and Diverticulitis. (a) What is the treatment of diverticulitis?
9. Define Hydronephrosis. (a) Etiology, (b) Treatment.
10. Give the etiological agent or agents in Epidemic Pleurodynia. (a) Elicit the important clinical manifestations; (b) Name the most frequent complication; (c) Treatment.

Pathology

1. The patient is a 45 year old white male with history, physical findings and x-ray evidence suggesting a lesion causing bronchial obstruction near the hilus of the right lung. List in the order of probability, five possible types of lesion. In a parallel column, list such helpful or substantiating laboratory examinations as may be available.
2. The patient is a 55 year old white male with history and physical findings suggesting pericarditis. List in the order of probability five possible causes. In a parallel column, list such helpful or substantiating laboratory examinations as may be available.
3. List five sites at which peptic ulceration may occur in the gastro-intestinal tract. In a parallel column, list the causative factor or factors. Describe the microscopic appearance of a typical peptic ulcer.
4. Name two renal lesions which are limited largely to diabetics. List the outstanding clinical and laboratory features of each. Briefly describe each microscopically.
5. Which testicular tumor (a) Is composed of large sheets of uniform appearing cells with little stroma and no particular grouping? (b) Most often gives a positive A. Z. or Friedman test? (c) Has the poorest prognosis? (d) Has the best prognosis? (e) Is the most common?
6. What is the significance of a positive report on a cervical cytology specimen and how should the patient be managed?
7. List in the order of probability five possible causes of disseminated osteolytic lesions in a 50 year old female. In a parallel column, list helpful laboratory examinations and their characteristic findings.
8. In a 20 year old patient with signs of meningeal irritation and the following spinal fluid findings, list in the order of probability five possible causes, and in a parallel column list helpful or confirmatory laboratory tests: Pressure, slightly increased; Appearance, clear; Clot, none; Protein, 100 mgm. per 100 cc.; Cells, 400 Cu. mm., 90% lymphocytes; Sugar, 40 mgm. per 100 cc.; Chloride, 600 mgm. per 100 cc.; Gold curve, 0002321000.
9. In a 60 year old white male with Hb. 7.7 gm. per 100 cc., RBC 2,000,000 per cu. mm., packed cell volume 23%, WBC 4200, neutrophiles 50%, lymphocytes 45%, monocytes 3%, eosinophiles 2%, platelets 110,000; what disease or diseases would you suspect and what other diagnostic procedures would you suggest?
10. In a 35 year old female with symptoms and signs of hyperthyroidism: (a) Give brief gross and microscopic description of the thyroid gland. (b) Give the typical values for basal metabolic rate, protein bound iodine, radioactive iodine uptake, cholesterol, and glucose tolerance.

Surgery

1. Define: (a) euthyroidism; (b) Hypothyroidism; (c) hyperthyroidism. Discuss each briefly from the standpoint of: (a) palpable findings; (b) laboratory findings.
2. Give the possible causes of the "dumping syndrome" in the post-gastrectomized patient, and indicate diagnostic data and corrective measures.
3. Discuss "cord bladder" as regards diagnosis and treatment.
4. Discuss diagnosis and treatment of carcinoma of the left colon and differentiate it from similar pathology in the right colon.
5. How would you treat: (a) Post-operative acute

pancreatitis; (b) Post-operative acute urinary retention; (c) Post-operative paralytic ileus; (d) Post-operative diarrhea due to antibiotic therapy; (e) Post-operative parotitis.

6. Define intussusception. What is the most frequent cause in childhood? In the adult?
7. How would you manage a case of intestinal obstruction, giving your clinical diagnostic, laboratory, and treatment approaches. A list without lengthy discussion should be used.
8. Describe the so-called "whip-lash" injury of the neck, indicating the mechanics of the injury, the treatment, and the prognosis.
9. Give a concise, but descriptive differential diagnosis in a case of right lower quadrant abdominal pain.
10. Given a palpable mass or fullness in the left upper quadrant of the abdomen, outline the differential diagnosis, and include diagnostic procedures.

Obstetrics and Gynecology

1. Give the indications and contraindications for treatment of uterine leiomyomata (fibroids) by: (a) Myomectomy; (b) Supracervical hysterectomy; (c) Total hysterectomy; (d) Irradiation therapy (x-ray or radium).
2. Briefly discuss the diagnosis, prognosis, and treatment of epidermoid (squamous cell) carcinoma of the cervix. (So-called stage 0 or carcinoma-in-situ).
3. Give the management and treatment of post-menopausal bleeding.
4. What is the significance of slight bleeding of short duration occurring regularly at midpoint of an otherwise normal average 28 day menstrual cycle?
5. Describe endometriosis and give symptoms which accompany it. What is the treatment?
6. How is the diagnosis made of fetal death in early pregnancy? In late pregnancy? Indicate treatment in each case.
7. Define placenta praevia. What is the main symptom of this and why does it not appear in most patients until the last trimester of pregnancy?
8. What signs and symptoms observed in a pregnant woman are indicative of toxemia of pregnancy? Outline management and differentiate from a case of essential hypertension.
9. What are the causes of habitual abortion?
10. Why is breech delivery hazardous for both the mother and the infant?

Specialties

1. Draw the normal visual form field for the right eye when taken with a 10 mm. white test object at 1/3 meter distance and locate the physiological blind spot.
2. Describe the visual field findings in the case of a man 62 years of age who has well advanced, bilateral, chronic, simple, wide angle glaucoma with normal central vision for distance.
3. A mother brings a 7 year old boy to your office with the history that she has received a notice from the school that he has bilateral defective hearing. What examination would you make and what would you look for and what advice would you give the mother?
4. Name five common diseases which may cause generalized pigmentation of the skin.
5. Classify tumors of the testis. What is the most common form of testicular tumor and what is its management?

Preventive Medicine and Hygiene

1. Discuss from the view point of public health, the cause and prevention of goitre.
2. When is inoculation against typhoid fever advisable? How soon would treatment become effective? What degree of protection may be expected? How long will the inoculation be effective?
3. What measures are desirable and practical for the prevention of the dissemination of disease by food handlers?

4 and 5. (Use one sheet of paper for this answer). In "Civil Defense" there has been a catastrophe in a nearby city and many residents become evacuees. Your area is designated for reception of these evacuees. Draw a plan sketch for an area on a water course for such a camp, showing water course, direction of flow, access roads, land slope, drainage, natural advantages, location of facilities, necessary shelter, provision for housing (tents or barracks), feeding, handling of persons sent to the camp, sanitary arrangements and lay-out of grounds. Label on the plan each item so that others may understand how to proceed with building and installation.

* * *

Licensed Through Endorsement by State Medical Board

The State Medical Board of Ohio has issued licenses to practice medicine and surgery in the State to the following physicians through endorsement of their licenses to practice in other states, or certification by the National Board of Medical Examiners (included are intended residence and medical school of graduation):

April 1, 1958—August Robert Bauer, Jr., Columbus, University of Michigan; Danute G. Bieliauskas, Cincinnati, University of Leipsic, Germany; Ying-Chei Chen, Cleveland, National Sun Yat-Sen Medical School, China;

Alexander McGill Duff, Jr., Mansfield, Johns Hopkins University; Robert C. Lam, Peiping Union Medical College; Jane Mutuzel, University of Latvia; Gunars Medins, Akron, University of Marburg, Germany;

Leszek Ochota, Cambridge, University of Zurich, Switzerland; Zabih Sadighian, Teheran University, Iran; Nicholas Vasilkovs, Dayton, University of Wurzburg, Germany.

June 19, 1958—Robert Cain Atkinson, Columbus, Univ. of Tennessee; George Pickering Balz, Cincinnati, Univ. of Illinois; David Barr, Cleveland, Cornell Univ.; Fred "G" Blum, Jr., George Washington Univ.;

Clifford Richard Boeckman, Akron, Marquette Univ.; Richard John Bonistalli, Marquette Univ.; Warren Edgar Bontrager, Akron, Univ. of Michigan; Joseph Franklin Boyd, Jr., Toledo, Meharry Medical College; Raymond Richard Buganski, Toledo, St. Louis Univ.; Alfred Peter Bukeavich, Findlay, Univ. of Pennsylvania; Jack Mehl Burnett, St. Clairsville, Johns Hopkins Univ.;

David Michael Carberry, Akron, Jefferson Medical College; William Thomas Carter, Columbus, Univ. of Virginia; Albert Charles Casabona, Jr., Cleveland, Univ. of Pittsburgh; Louis Justin Cherry, Marion, Univ. of Pittsburgh; Thomas Christie, Univ. of Glasgow, Scotland; Roy Henry

Clauss, Cincinnati, Northwestern Univ.; Henry Frank Dale, Univ. of Berlin, Germany;

Geary Malvin Eicher, Jr., Steubenville, Univ. of Pittsburgh; Henry Steven Ellison, Youngstown, Howard Univ.; Henry Theador Forsyth, Toledo, Univ. of Michigan; Martha Neal Franz, Dayton, Indiana Univ.; Marcus Ronald Gilliss, Cleveland, George Washington Univ.; Thomas Millard Hamilton, Gallipolis, Columbia Univ.; Jesse Doddridge Hayes, Jr., Dayton, Indiana Univ.;

William Joseph Hockett, Jr., Bowling Green, Loyola Univ.; Allen Howard Holt, Youngstown, Syracuse Univ.; Harold Byron Houser, Cleveland, Indiana Univ.; Robert John Hritzo, Youngstown, St. Louis Univ.; Galen Carl Huffman, Columbus, Indiana Univ.; Richard Edward Hurley, Cleveland, Univ. of Utah;

Roger Woodham Jelliffe, Cleveland, Columbia Univ.; Allan MacKenzie Johnstone, Tulane Univ.; Lotus Morris Jones, Cleveland, Meharry Medical College;

Kenneth Leroy Kaminski, Cleveland, Georgetown Univ.; Frederick Maurice Kapetansky, Columbus, Univ. of Michigan; Ralph Katz, Cleveland, Univ. of Basel, Switzerland; William Eugene Kincaid, Cleveland, Medical College of Virginia; William Wolfgang Koslow, Univ. of Basel, Switzerland; Francis Eugene Kulcsar, Portsmouth, Univ. of Debrecen, Hungary;

Wilhelmina Lendl, Univ. of Berlin, Germany; Sidney Issaac Lerner, Columbus, Univ. of Maryland; Ira Mortimer Levy, Cleveland, Univ. of Texas; Hughie L. Lindsey, Canton, Howard Univ.; Winifred Liu, Warren, National Hsiang Ya Medical College, China; William Gideon Lockhart, Cleveland, Univ. of Arkansas;

Douglas W. Macdonald, Cleveland, Univ. of Ottawa, Ontario, Canada; Joseph John Maher, Cleveland, Georgetown Univ.; Walter Hugh Maloney, Cleveland, Temple Univ.; Walter D. Mazzacane, Royal University of Naples, Italy; Roy Lewis McKittrick, Cleveland, Columbia Univ.; Michael Vincent Miklos, Cleveland, Univ. of Pittsburgh; Charles Edward Miller, Columbus, Vanderbilt Univ.; Harry Robert Miller, Toledo, Indiana University; Margaret Bowers Miller, Toledo, Indiana Univ.; John Richard Mollenkopf, Cleveland, Stanford Univ.; Walter Alexander Murray, Jr., Columbus, Cornell Univ.; Guy Reed Musser, Warren, Jefferson Med. College;

James Stephen New, Zanesville, Univ. of Georgia; Charles Donald Noonan, Cincinnati, Univ. of California; Rudolf Reuven Oestreicher, Univ. of Prague; John Francis O'Neill, Cincinnati, Georgetown Univ.; Charles Roger Oppegard, Cincinnati, Univ. of Maryland;

Boyd Nelson Park, Cleveland, Temple Univ.; Charles Nathan Patton, Akron, Univ. of Illinois; Paul Earl Peckham, Cincinnati, Johns Hopkins Univ.; John J. Pelosi, Toledo, Georgetown Univ.; Robert Louis Perkins, Mt Vernon, Johns Hopkins Univ.; Nelson Glasgow Richards, Cleveland, Univ. of Virginia;

Herbert Henry Schneider, Univ. of Bern, Switzerland; Francis Joseph Seiler, Dayton, St. Louis Univ.; Leroy Shear, Cleveland, Univ. of Maryland; Eugene Sherman, Mansfield, Chicago Medical School; Albert Sion, Warren, University of Antioquia, Columbia, South America;

Howard H. Smead, Lorain, State Univ. of Iowa; Blanca Smith, Columbus, Nat. Univ. of Brazil, S. America; Robert L. Smithwood, Worthington, Indiana Univ.; J. Clyde Spencer, Jr., Univ. of Michigan;

Joseph William Tandatnick, Youngstown, Anderson College, Scotland; Theodore Benjamin Thoma, Steubenville, Jefferson Med. College; Benjamin Chee Keong Tom, Dayton, Hahnemann Med. College; Norman Traverse, Columbus, Univ. of Tennessee;

John Wade Walker, Jr., Univ. of Louisville; Robert Owen Webster, Cleveland, Univ. of Michigan; Cornelius Calvin Welch, Cleveland, Creighton Univ.; Paul Roberts Winslow, Columbus, Univ. of North Carolina.

Dr. Anderson Is Named to Post as Mental Hygiene Commissioner

Dr. Robert C. Anderson has been named state commissioner of mental hygiene, a position which makes him chief of the Division of Mental Hygiene, Dr. Robert A. Haines, director of the Department of Mental Hygiene and Correction, announced.

Dr. Anderson is a graduate of the University of Indiana Medical School, who came to Ohio last November after serving six years as manager of the Veterans Administration Hospital in Topeka, Kansas. He had also been clinical director of that institution since 1946.

He is a fellow of the American Psychiatric Association and is certified by both the American Board of Psychiatry and Neurology and by the American Psychiatric Association as a mental hospital administrator.

Dr. Anderson succeeds Dr. Joseph E. Duty, who resigned from the state post for health reasons. Dr. Duty returns to his post as superintendent of the Toledo State Hospital, a position he held for 11 years prior to becoming state commissioner last fall.

Dr. William Wells, of Newark, Is 1958 OSMGA Golf Champion

The Ohio State Medical Golfers' Association returned to the Springfield Country Club for its 1958 tournament. One hundred and twenty-five medical golfers participated in this year's play and enjoyed the difficult but beautiful Springfield course. The weatherman, often a conspirator against the golfing medics in the past, cleared the skies for 10 o'clock tee offs and kept them so until late afternoon when a cloudburst drenched late starters. Spirits were revived by the cocktail party given by the Clark County Medical Society preceding the annual banquet. Dr. Ray Turner, chairman of the Springfield Committee, provided arrangements and hospitality.

Dr. William Wells from Newark, captured the medical golfers' crown with a low gross of 39-35-74. His name will join previous champions on the W. D. Inglis Trophy. The champion is also awarded a replica of the large beautiful Inglis Bowl for permanent possession. Dr. Inglis of Columbus, a founder and early champion of OSMGA presented the trophy to the Association last year. Dr. Avis Franklin, Akron, and Dr. Earl Pinnell, Dayton, were tied for runner-up position with low gross of 75.

Other winners in age classes were awarded silver bowls and were as follows:

- 39 years and under
  - Low Gross—Avis Franklin, Akron
  - Low Net—L. M. Haley, Dayton
- 49 years and under
  - Low Gross—William Lovebury, Columbus
  - Low Net—J. Woodward, Euclid
- 59 years and under
  - Low Gross—G. E. Huston, Marietta
  - Low Net—H. R. Johanson, Kenton
- 69 years and under
  - Low Gross—H. D. Emswiler, Columbus
- 79 years and under
  - Low Gross—W. C. Fargo, Cleveland

Officers for 1959 elected by the membership were: President-Elect, John C. Stahler, Dayton; Vice - President, William Lovebury, Columbus; Secretary-Treasurer, Bob Elwell, Toledo. President Paul Stoodt, Mansfield, conducted the business meeting of the Association following the banquet of filet mignon and lobster and then installed the new president, Edward Sawan of Akron.

Dr. Sam Vinci of Cleveland, extended an invitation to the OSMGA to hold the 1959 tournament at the Accacia Country Club in Cleveland, which was unanimously accepted by the membership.—Robert Elwell, Secretary,Treasurer.

Eighth District Meeting Scheduled In Zanesville, October 2

The Annual Eighth District Medical Meeting is scheduled for Thursday, October 2, in Zanesville. Quarters for the meeting will be the Zanesville Country Club. The scientific meeting will be a symposium during the afternoon on "Neurological and Neurosurgical Disease." An evening dinner for physicians and their wives is planned. Additional information will be published in the September issue of *The Journal.*

ANA Acts on Health Insurance And Collective Bargaining

At its recent meeting in Atlantic City, the American Nurses Association acted on a wide variety of subjects, among them government health insurance and greater economic security for nurses. These significant actions were described as follows in the July issue of *The American Journal of Nursing:*

For the first time since 1952, the House of Delegates reviewed its policy on taking a position on national health insurance. Believing that the disabled, retired, and aged are neither eligible nor able to avail themselves of voluntary health insurance, the delegates adopted a resolution that the ANA support the principle of extending and improving contributory social insurance to include health benefits for recipients of old-age, survivors, and disability insurance, and that nursing services be included as a benefit of any health insurance program.

"In response to inquiry from the floor whether this action committed the ANA to support the Forand bill, the chairman of the committee on legislation said that it did not commit the association to support any particular bill. It did give the ANA Board the authority, she said, to review any bill on the subject in Congress and to support the bill or bills if they agreed with the principle expressed in the resolution, or to recommend changes."

* * *

"The delegates moved to strengthen the position of state nurses associations in collective bargaining with hospitals by adopting a resolution calling on the American Hospital Association and its constituents to join with the ANA and its constituents in implementing the essential procedures of collective bargaining: freedom of employees to organize; free choice of representation; recognition of employee representatives and bargaining in good faith by representatives of employers and employees; negotiation of agreements signed by both parties."

Selling Price of Medical Practice . . .

Facts, Comments and Suggestions on This Subject are Made by Director Of the AMA Bureau of Medical Economic Research Following a Survey

NOT infrequently, the Columbus Office is asked this question: "I want to sell my practice—What about the price?" Or, it is asked this question: "I have been offered a practice—What is a fair price for me to pay for it?"

There can be no cut and dried answers to these questions. Nevertheless there are some basic matters which should be taken into consideration by either the seller or the buyer.

One of the best articles on this subject was that prepared by Frank G. Dickinson, Ph. D., director, of the AMA Bureau of Medical Economic Research, several years ago, following a survey of secretaries of state medical societies and other sources.

Text of Article

Following is a part of Dr. Dickinson's article:

Some time during his professional career, a physician may face the problem of buying or selling a practice. After the physician completes his internship or residency, he may consider purchasing the practice of an older physician. After establishing himself in private practice, he may for various reasons contemplate a change of location, involving both the sale of his own practice and the purchase of another elsewhere. Following the retirement or death of a physician the sale or disposal of his practice may be considered.

The sale or purchase of a medical practice raises many questions; a considerable number of requests for information and advice are received at the headquarters of the American Medical Association. Perhaps the most frequent question concerns the means of establishing a proper selling price for a practice. But little has been published on this subject recently. Thoroughgoing studies have not been made of either the economic or legal aspects; nor have there been any compilations of actual experiences. The Bureau of Medical Economic Research recently conducted an informal survey among secretaries and executive secretaries of state medical societies and accumulated available facts from other sources.

Information and Suggestions

Current information concerning physicians' practices which are for sale may be obtained from several sources. A few state societies reported that they occasionally provide clearing-house facilities between parties; possibly most other societies would be willing to furnish available information. The medical journals are probably the most important source for such opportunities—including the classified advertising sections of local, state and national publications. Other avenues of approach for either the buyer or seller are medical placement agencies and inquiries among professional acquaintances. In addition, a physician wishing to purchase a practice may offer an advertisement.

Many of the secretaries of medical societies commented on the factors to be evaluated in ascertaining the selling price of a practice. Most of them considered that the tangible goods could be appraised readily but suggested that pricing of intangibles was extremely hazardous. The following is a list of types of goods, together with comments and suggestions, developed from available sources:

1. **Real and Personal Property and Equipment.**—Medical equipment, supplies and the physician's residence (if this is included) may be appraised by real estate brokers, equipment dealers and other consultants in order to establish a fair market value. Most authorities felt that these constituted the basic, if not the only value, of a medical practice.

2. **Transferable Contract Appointments.** — If the seller holds appointments as an industrial consultant or house physician, or holds other positions providing a salary or other regular remuneration, the possibility of transferring these to the buyer may be explored. A value equal to an agreed percentage, perhaps of the annual income for the first year, may be established for this assured income.

3. **Lease of Office Space and Residence.**—While housing and office space continue to be in short supply in many parts of the country, a money value may be established for the transfer of leases on desirable space of this nature.

4. **Uncollected Bills.**—Bills for current services to patients or for relatively recent services may be transferred to the new physician for some consideration, or other arrangements for collections may be made which will be mutually agreeable. Often, the selling physician or his heirs will retain them for collection through their own agents.

5. **Goodwill.**—A formula or procedure has not been suggested which might be used consistently to establish a cash value for goodwill. One secretary commented, "I am of the personal opinion that it is absolutely impossible for a physician to set a price on goodwill or the value of a prac-

tice as such." Another stated, "It depends to a great extent on the value of services, character and personality. One doctor may not be able to give the same services as the previous physician, or to pick up and use the goodwill left behind because of difference in personalities or other intangibles, and thus may lose all the goodwill." The general conclusion was that since the personal element is so important in the services provided by a physician, it may not be valid to assume that a physician's goodwill can be sold in the same fashion as a manufacturer's or a retail store's goodwill.

6. **Patients' Records.**—The problem of evaluating patients' records as to goodwill is even more difficult. Case histories, diagnostic reports, financial and other records can be of great value in assisting a new physician in the treatment of patients of the former physician. Many secretaries, however, felt that patients' records were essentially intangibles and therefore difficult to price. In addition, one secretary pointed out that ethical and legal issues are involved in transferring such records to a buyer without the patients' consent. To some extent this objection may be overcome if arrangements are made to have the buyer introduced to the community by the retiring physician as a professional associate for a period of time. Several secretaries felt that this is a more valuable arrangement in rural areas than in urban areas.

No Rules of Thumb

The buying physician may agree that the location, introduction to old patients or other circumstances will assure a steadier patient load than if he were to start a practice without these advantages. Basically, any inherent money value in these intangibles is reflected in the number of old patients who will continue to come to the buying physician. The buying physician may agree to pay the seller a given percentage of net income received from old patients during the first year or two; new patients during the first year may or may not be considered a separate or additional goodwill item. It should be clear to both parties that generalizations or "rules of thumb" regarding the probable percentage of old patients who will accept the new physician are open to serious question when applied to a given situation. Since prediction is so hazardous, both parties would be well advised to provide for final determinations of this item of goodwill a year or two later, although the formula may be set forth in the contract. This arrangement is considered also in cases in which a partnership or group is dissolved, but often it will involve much more complex formulas for establishing the interest of each member.

Careful consideration from the point of view of medical ethics should be given to any mutually satisfactory arrangement providing payments for the goodwill item out of future income or basing the value of this item on future income.

Specialty Practice

The question of sale or purchase of a specialty practice involves further difficulties. As a specialist depends greatly on referred patients, greater care must be taken to verify the continuation of a sound relationship with referring physicians. A general suggestion, both for a specialty practice and for a general practice, is to consider employment of a young man on a salary basis, with agreement as to terms of eventual sale or shift to partnership activity. In some instances such an agreement might prove more satisfactory to both parties than an outright sale.

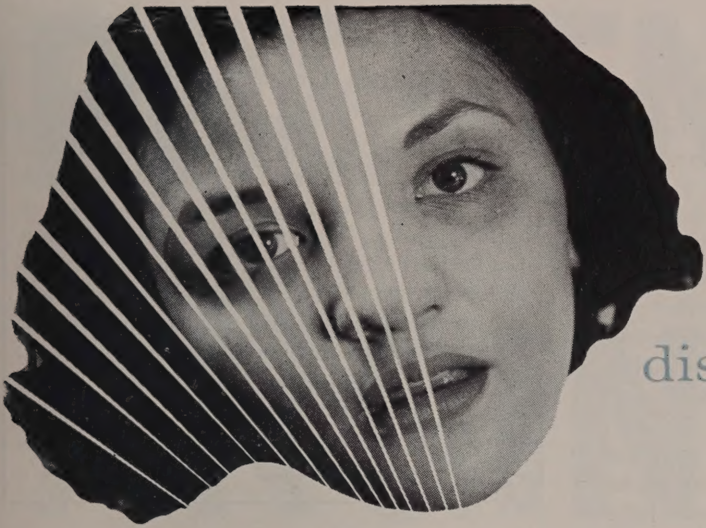
Conclusions

The physician should exercise extreme care in arranging to sell or purchase a practice. Perhaps the best statement on the problem is the following by one of the state secretaries:

> The location, the type of practice, the size of the practice and the competition that is present are all factors which must be considered in each individual sale, and it appears that probably there is no formula that can be set up—even with an area such as a state—that would assist in any individual transaction. I am inclined to look on this as an individual business venture that would depend entirely on an agreement between the parties concerned. Even though in the eyes of every one else the purchase price was too high or too low, if it was agreeable to the two parties concerned, it would still be a happy transaction. And for those reasons, it has been the opinion of the society that it would not interfere or attempt to offer any assistance to persons contemplating the purchase of a practice.

Because of the extremely involved professional and financial interests arising out of such negotiations, the Bureau of Medical Economic Research strongly urges that principals make no final arrangements without the assistance of their attorneys. This is especially true if the transaction cannot be consummated at once but involves payments or professional relationships, such as partnerships, which extend over a period of time.

One alternative to the purchase of a practice was suggested by several secretaries—the establishment of a new practice in a community. If, after exploring the advantages and disadvantages of buying a given practice, it appears that there is no singular value in the location, type of practice or tangible goods, the physician can given serious consideration to the selection of another location in the community. It is this alternative which largely accounts for the infrequency of sales and the tenuous value of the goodwill item in medical practices in the United States.



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*A Symposium on the Pharmacologic Effects of Dartal on the Liver, Chicago, Searle Research Laboratories, Feb. 7, 1958.

Columbus Academy Announces "Clinic Day" Nov. 1

The Columbus Academy of Medicine has announced plans for the second annual "Clinic Day" program to be held Saturday, November 1 at the new Franklin County Veterans Memorial Building, 300 W. Broad Street in Columbus. Interested physicians of other counties are invited to attend.

The program announced by Dr. Arthur G. James, general chairman, includes nine out-of-state speakers. Final details will be announced in other issues of *The Journal,* and plans for pre-registration will be given.

Registration will begin at 8:30 a.m. with the first program feature at 9:30. The following speakers with the topics on which they will speak have been announced:

Morning Program

Dr. Paul Hodges, professor of radiology, University of Chicago, "Radiation Hazards in medicine."

Dr. Ray W. Gifford, consultant, Section on Medicine, Mayo Clinic, Rochester, Minn., "Fat, Diet and Atherosclerosis."

Dr. Rachmiel Levine, chairman, Department of Medicine and director of metabolic and endocrine research, Michael Reese Hospital, Chicago, "Newer Agents in Diabetes."

Dr. Robert J. Samp, Department of Surgery, Tumor Clinic, Wisconsin University School of Medicine, "Prevention of Cancer, Forty Possible Means."

Afternoon Program

Dr. Joseph E. Murray, Boston, Mass., "Experiences with Kidney Transplants."

Panel Discussion on Care of the Advanced Cancer Patient; Moderator, Dr. Charles A. Doan, dean of the Ohio State University College of Medicine.

Panel Collaborators: Dr. George T. Pack, attending surgeon, Memorial Hospital, New York City; Dr. Chester Southam, associate, Sloan-Kettering, New York City; Dr. Bronson S. Ray, professor of neurosurgery, Cornell University, New York City; Dr. James W. Carpender, professor of radiology, University of Chicago.

Cleveland—Dr. George Austen, Jr., Western Reserve University School of Medicine faculty member, has accepted the post as chairman of the Department of urology and professor at the Boston University School of Medicine.

Wakeman—Two new physicians who recently elected to practice medicine in Wakeman were honored by the community at a reception in the Townsend-Wakeman High School Auditorium.

Still Time To Order

Doctor, you still have time to order the two pamphlets—"Do You Like to Make Decisions?" and "The Fifth Freedom"—which you received samples of in your June 16 *OSMAgram.* Your colleagues found these pamphlets on free choice and mutual understanding very effective. They ordered them in considerable numbers and you may do so without charge by writing OSMA Headquarters. Be sure to include your return address and the number of copies of each pamphlet you want. Ten copies or 1,000, we have them for you.

Do You Know?

OSMA Executive Secretary Charles S. Nelson participated in a round-table discussion of "The Doctor and His Medical Society," which appeared in the May issue of *The New Physician* as one of a continuing series in the Student AMA publication.

* * *

Governor C. William O'Neill has reappointed Dr. Claude S. Perry, Columbus, to the Ohio Commission for the Blind. The new five-year term ends in July, 1963.

* * *

Dr. Charles A. Doan, dean of the Ohio State University College of Medicine, was elected first vice-president of the American College of Physicians at the recent Atlantic City convention.

* * *

Dr. Margaret Jane Schneider, Cincinnati, was elected first vice-president of the American Medical Women's Association at the recent annual meeting in San Francisco.

Ohioans Will Speak at Rhinologic Program Scheduled in Chicago

Two Ohio physicians are scheduled to appear on the program of the American Rhinologic Society in Chicago, October 17-18. The meeting will be at the Palmer House.

Dr. Harvey C. Gunderson, Toledo, will speak on the subject, "Second Golden Decade of Rhinologic Surgery—Advances of the Past 10 Years."

Dr. Irving Cramer, Cleveland, will speak on "Nasal Physiology."

Details may be obtained from the secretary, Dr. Robert M. Hansen, 1735 North Wheeler Ave., Portland 17, Oregon.

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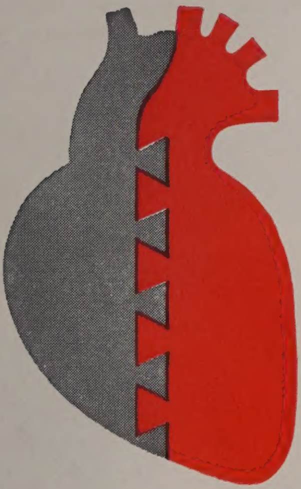

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1. *Friedlander, H. S.: The role of ataraxics in cardiology. Am. J. Card.* 1*:395, March 1958.*
2. *Shapiro, S.: Observations on the use of meprobamate in cardiovascular disorders. Angiology* 8*:504, Dec. 1957.*

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Guardianships . . .

Here Is a Practical Discussion of the Medical Aspects of This Subject Particularly as It Relates to Physicians Who Undertake To Treat Wards

AN attorney with a good deal of experience in matters of guardianships wrote this informal discussion of the nature of guardianships with emphasis on certain responsibilities and hazards which a physician may face when involved in treating patients who are wards. The author is Clarence C. Fowerbaugh, Cleveland, and the article is quoted from the *Bulletin of the Cleveland Academy of Medicine.*

* * *

The creation of the relationship of guardian and ward in Ohio is statutory and is a legal device protecting such person as is incapable of caring for himself, owing generally to incompetency or minority.

"Incompetency" applies to any person who by reason of advanced age, improvidence or mental or physical disability or infirmity is incapable of taking proper care of himself or his property or fails to provide for his family or other persons for whom he is charged by law to provide.

One under 21 years of age in Ohio is a minor and is entitled to a degree of protection by virtue of being a minor.

Type of Guardianship

Guardianship may be established of the person, the estate or the person and estate. A guardian of the estate is, to a great extent, only a business or financial manager. A guardian of the person, in the case of a minor, stands in the relationship to such child as a parent or parents. This invests the guardian with the right of choice of schools, place to live and other incidents of the parent-child relationship. The guardian of the person of an adult who is incompetent, regardless of cause, stands in a position of a protective relation-

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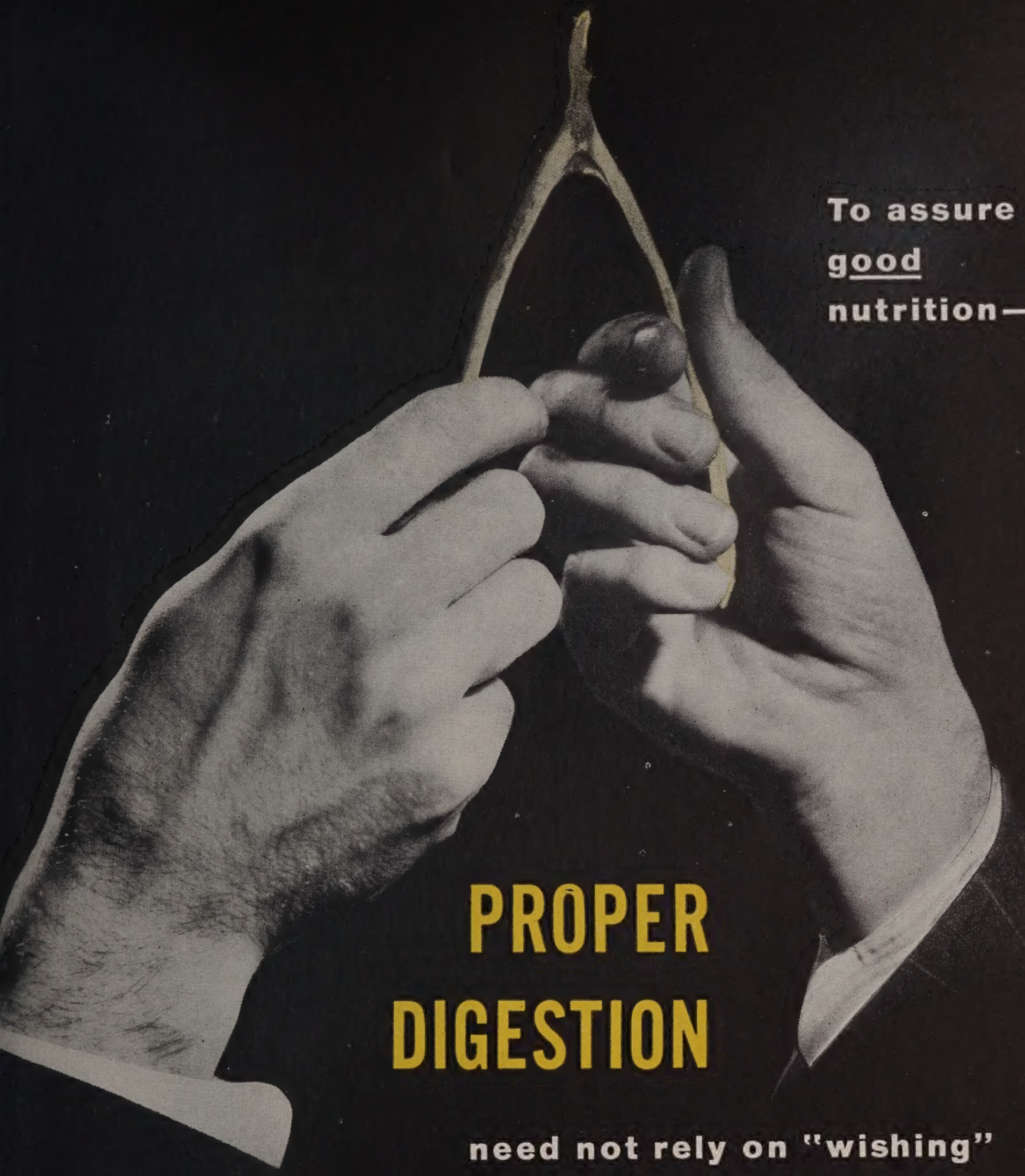

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ship, making the decisions for his ward the same as he might do if competent.

In Ohio, the probate courts have jurisdiction of all guardianships, that is, their creation, continuance and supervision. While a guardian may be removed for cause by the Probate Court, such Court cannot be expected to substitute its judgment in routine decisions for that of the guardian.

In general, a physician is not needed in the creation of a guardianship-ward relationship as it applies to minors. Parents, or surviving parent, are the natural guardians of their minor child or children. In most instances where the guardianship is created for a minor, the child is an orphan or has been abandoned by his parents so that some other person must be appointed to stand in the legal parent-child relationship toward the child.

Medical Necessity

To create the guardianship-ward relationship with an adult, the courts, except in certain limited instances where the written consent of the ward is given, require medical evidence as to the necessity for the appointment of a guardian. Frequently the creation of the guardianship for an adult is denied entirely because of medical testimony. Courts do not have a guardian appointed merely because another can do a better job of managing his person and property.

Habitual drunkenness, insanity, imbecility, mental illness, physical infirmity and advanced age constitute the common grounds for the appointment of a guardian. The role of the physician in the diagnosis of such conditions is readily apparent.

The law as a protective device for the ward, requires that the guardian be bonded, and that periodic accounts of all income and expenditures be filed. While the guardian serves the ward, the Probate Court keeps the guardian under surveillance with the view of seeing that a high degree of protection is afforded the ward.

A minor, in general, is not liable in contract except for necessaries, and an adult dealing with a minor, with the above exception, does so at his own peril. The guardianship of an adult, to a great extent, removes the contractual rights and privileges of such adult ward. The guardian handles the ward's finances, pays his bills and does his contracting for him. The appointment of a guardian, in almost all instances, deprives the ward of the right to drive a car. One dealing with an adult ward, in general, does so at his own peril.

A guardian is not liable out of his own assets to support, maintain and pay medical expenses of his ward. Such payments must come out of the guardianship estate. A guardian may, by contract,

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GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, two weeks, Sept. 8. Vaginal Approach to Pelvic Surgery, one week, Oct. 6. General & Surgical Obstetrics, two weeks, Sept. 22.

MEDICINE—General Review Course, two weeks, Oct. 20. Electrocardiography, two-week basic course, Oct. 6. Gastroscopy & Gastroenterology, two weeks, Nov. 3. American Board Review Course, one week, Sept. 29. (For Part 1 Candidates Only)

DERMATOLOGY—Clinical & Didactic Course, two weeks, Nov. 3.

UROLOGY—Two-Week Intensive Course, Oct. 13. Ten-Day Practical Course in Cystoscopy by appointment.

RADIOLOGY—Diagnostic X-Ray, two weeks, Sept. 22. Clinical Uses of Radioisotopes, two weeks, Sept. 29.

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References: 1. Groskloss, H. H., et al: Clin. Med. 2:885 (Sept.) 1955. 2. Goldsmith, J. W.: Minnesota Med. 40:99 (Feb.) 1957.

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bind himself to pay out of his own assets obligations of his ward, but this does not generally occur.

Points To Watch

A physician, in dealing with an incompetent or with a guardian, should be aware of the following:

1. If a ward calls a physician for medical services, unless it be an emergency, the doctor may run the risk of not being paid by the guardian.
2. The guardian and not the ward has the legal right to choose a physician and to select the hospital, if this should be necessary.
3. In all instances, except emergencies, where written consent for treatment, shock therapy, operations and hospitalization are required, the guardian gives such consent and not the ward.
4. Payments for such services are made by the guardian and not by the ward, even though the actual funds come from the ward's assets.
5. The guardian relationship terminates upon the death of the ward, so that the guardian is not in a position, legally, to consent to an autopsy.
6. A guardian, in most jurisdictions, is not in a position to consent to his ward's sterilization. In Ohio, in absence of statutory authority, the guardian cannot consent on behalf of his ward to sterilization, and the ward being incompetent or incapable of contracting, cannot consent on his own behalf.
7. A physician, in recommending to a probate court whether or not a guardian is necessary for an adult person, should be free from bias or prejudice and should use his best professional experience. The fact that a person has made a series of errors in business judgment is not sufficient cause for a guardianship. Limited intelligence, alcoholism and mildly advanced cases of senility may not be sufficient reasons to require a guardian.
8. The fact that another may handle his ward's financial assets better is not a basis for the appointment of a guardian. One has the right, in our democracy, to a certain number of errors of judgment.

Professional Opinion

A physician may find himself in a delicate situation, particularly when requested to examine a patient either as to the necessity for appointment of a guardian or the termination of a guardianship. Suppose the friend of the alleged incompetent requests the services of a physician prior to the appointment of a guardian and it is the doctor's opinion that a guardianship is unnecessary, such doctor cannot legally demand payment for his services by the alleged incompetent as there was no express or implied promise of compensation. If the person requesting the services originally

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does not make the payment, the doctor can usually add this experience to his accumulated charitable endeavors.

In a recent situation in an existing guardianship, an acquaintance of the ward sought the services of a physician in having the guardianship terminated. After extensive medical examination by the physician and by a physician obtained by the guardian, it was their medical opinion that the guardianship should not be terminated. The physician engaged by the guardian was paid promptly out of the ward's assets for his services rendered and for benefits to the ward. The other physician, while acting in good faith, was not paid by the person who engaged him, and as he had not been engaged by the guardian, there was no legal obligation on the part of the guardian to pay.

A guardian cannot be unjust, unreasonable or arbitrary in his relationship with his ward or with others, as he is under the jurisdiction of the court. The guardian is the person vested with the responsibility for his ward.

Doctors' Appeal for Radio Frequencies Temporarily Rejected by FCC

Separate requests by American Medical Association and American Hospital Association for exclusive radio frequencies for use of physicians and hospitals have been temporarily rejected by the Federal Communications Commission in one classification, but a FCC spokesman said their overall appeals still are under consideration with the possibility they eventually will be made eligible in several other classifications.

In the same ruling the FCC set up a new classification, "Business Radio Services," and made doctors and hospitals eligible for frequencies in it. However, under these conditions the medical profession would have to compete with all community businesses for the frequencies.

They are also eligible in the "Special Emergencies" and "Citizens Radio" classifications, but under restrictions and competitive conditions that would not make these frequencies attractive to doctors or hospitals.

The AMA and AHA still have a right to make a new appeal for frequencies in the "Industrial Radio Services" category, in which their original request was denied.

Doctors are asking for protected frequencies for physicians for day-to-day use, to receive and answer emergency calls, for undergraduate and post-graduate medical training, and for use in disasters or medical emergencies. The hospitals want the service for day-to-day and emergency use.

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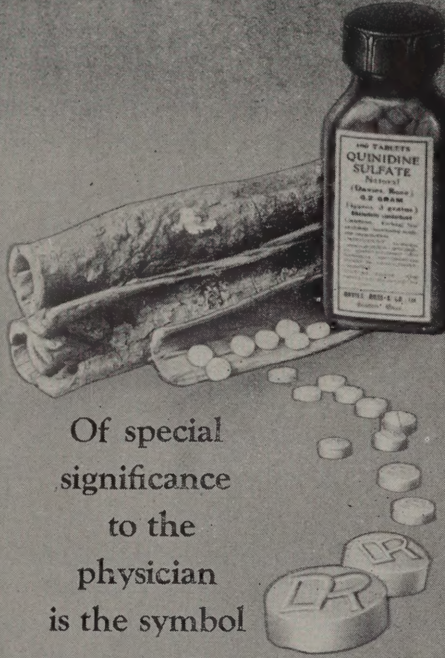

Of special significance to the physician is the symbol

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When the physician writes "DR" (Davies, Rose) on his prescriptions for Tablets Quinidine Sulfate, he is assured that this "quality" tablet is dispensed to his patient.

Rx Tablets Quinidine Sulfate Natural
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Q-7

New Members of OSMA

The following are the names of the new members of the Ohio State Medical Association since June 1, 1958. The list shows the county in which they are affiliated, city in which they are practicing or temporary address in cases where physicians are taking postgraduate work.

Ashtabula County
Richard S. Millberg, Andover

Clark County
John W. Rechsteiner, Springfield

Cuyahoga County
Alfred K. Bochner, Cleveland
Sylvester S. Davis, Jr., Cleveland
Aaron J. Fine, Cleveland
Antoine M. Harouny, Cleveland
Wade S. Helwig, Cleveland
Louise J. Keating, Cleveland
Juan H. Montier, Cleveland
Gaetano Roncagli, Cleveland
Myra Sahajdak, Cleveland
Robert K. Saylor, Cleveland
Carlos A. Schaffenburg, Cleveland
Burton J. Shapiro, Cleveland
Chandler Smith, Cleveland
Nancy Cole Wallick, Cleveland
Robert W. Wido, Cleveland
Stephen N. Wiener, Cleveland
Herbert L. Winograd, Cleveland

Franklin County
Talivaldis Berzins, Columbus
Arthur L. Clark, Columbus
Robert J. Dane, Columbus
Morton L. Harshman, Columbus
Thomas L. King, Columbus
Norloso B. Livingston, Jr., Columbus
Jacob W. Old, Jr., Columbus
William T. Paul, Columbus
Ivan G. Podobniker, Columbus
Bartholomew D. Ragucci, Columbus
Ruth H. Ragucci, Columbus
Norman E. Sindel, Columbus
Nichols Vorys, Columbus

Hamilton County
Robert T. Bliss, Cincinnati
Harry H. Boss, Cincinnati
Thomas E. Finn, Cincinnati
Thomas L. Linn, Cincinnati
Paul H. Ornstein, Cincinnati
Chester M. Pierce, Cincinnati
Edward A. Rowat, Cincinnati

Harrison County
Kurt W. Michaelis, Hopedale

Lake County
Hellmuth E. Simon, Painesville

Lorain County
John J. Harrington, Lorain

Putnam County
Charles R. Kidd, Kalida

Richland County
Val Berzzarins, Lexington

Summit County
Alfred C. Buergler, Akron

Middlefield — The Middlefield Chamber of Commerce has named as its "Man of the Year" for 1957, Dr. Hubert Shafer, for his 31 years of medical service and community leadership.

Zanesville—A Bradenton, Fla., general practitioner, Dr. R. O. Jones, has been named commissioner of the Muskingum and Guernsey County Health Departments. Dr. Jones, M. P. H., succeeds the late Dr. Margaret O'Neal.

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① Fibre-free **HYPOALLERGENIC** formula.

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③ An ideal food for milk allergies, eczema and problem feeding.

SOYALAC helps solve the feeding problem of prematures and infants requiring milk-free diet.

Strikingly similar to mother's milk in composition and ease of assimilation, babies thrive on SOYALAC.

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CONCENTRATED
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Hypoallergenic
For Infants
Children and Adults
Loma Linda
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CONTAINS 15.5 FL. OZ.
NET WT. 17.3 OZ

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Medical Progress Cited By Laymen in AMA Journal

"Partners in Progress" was the subject of a special salute to medicine on the occasion of the seventy-fifth anniversary of the *Journal of the American Medical Association.*

The salute was composed of a series of 20 articles tracing the interdependence of medicine and the community. They appeared in the July 12 *Journal of the AMA.*

Only one physician—Dr. Gunnar Gundersen, AMA president—was included among the authors. The remainder are acknowledged lay leaders in the fields of business, commerce, and industry.

Explaining why laymen were asked to contribute articles to a medical publication, Dr. Austin Smith, editor of the *Journal,* said "too often our eyes and our thoughts remain confined to our own fields of interest without realizing how much each field contributes to another."

We are all "partners in progress," he added, and no field of human endeavor can be isolated from the rest of the community.

Those who contributed articles for the *Journal's* anniversary were:

A. P. Beutel, vice-president and general manager, Dow Chemical Company; Roger M. Blough, chairman of the board, United States Steel Corporation; L. L. Colbert, president, Chrysler Corporation; John Daly, vice-president, American Broadcasting Company; James E. Day, president, Midwest Stock Exchange.

Walt Disney, chairman of the board, Walt Disney Productions, Ltd.; Frederic W. Ecker, president Metropolitan Life Insurance Company; Dr. Gunnar Gundersen, president, American Medical Association, Harlan Hatcher, president, University of Michigan; J. Edgar Hoover, director, Federal Bureau of Investigation, United States Department of Justice.

Charles F. Kettering, research consultant and director, General Motors Corporation; Herbert R. Mayes, editor, Good Housekeeping magazine; Fowler B. McConnell, board chairman, Sears Roebuck & Co.; Charles S. Rhyne, president, American Bar Association; Capt. Eddie Rickenbacker, chairman of the board, Eastern Air Lines, Inc.

Charles B. Shuman, president, American Farm Bureau Federation; Frank Stanton, president, Columbia Broadcasting System; John Steinbeck, author; DeWitt Wallace, publisher, *Reader's Digest;* K. L. "Tug" Wilson, commissioner, Intercollegiate Conference, and president, U. S. Olympic Committee.

In the same issue, President Dwight D. Eisenhower extended his personal "felicitations" to the *AMA Journal.*

The Chief Executive said the *Journal* is "a potent force for progress in the field of medical discovery and medical information."

Additional $6 Million Voted By Legislative for Poor Relief

At the recent special session of the Ohio General Assembly, an additional $6 million was appropriated from state funds for poor relief fund matching with the local relief areas. It is estimated that this will permit the state to meet its 50-50 matching obligation to February, 1959, when the General Assembly in regular session will take another look at the poor relief financial situation.

Buckeye News Notes

Bellefontaine—The Bellefontaine Kiwanis Club has bestowed its distinguished service award on Dr. A. J. McCrecken.

Cleveland—Dr. E. Perry McCullagh was installed as president of the National Endocrine Society at San Francisco June 19.

Dayton—Dr. Thomas P. Sharkey was elected treasurer of the American Diabetes Association at the group's 18th annual meeting in San Francisco June 22.

East Liverpool—Dr. C. H. Bailey recently was enrolled as a member of the University of Michigan Emeritus Club, whose members graduated 50 years or more ago. Dr. Bailey received his medical degree in 1908.

Garfield Heights—John R. Lawrence Post 304, American Legion, has named Dr. Charles Blaugrund its 1957 "Man of the Year."

Gomer—Dr. and Mrs. O. S. Robuck on June 22 observed their golden wedding anniversary. Dr. Robuck has been a patient in Lima Memorial Hospital since a fall March 11.

Hamilton—A Philadelphia, Pa., physician, Dr. Alexander Witkow, has assumed the position of director of public health for Hamilton and Butler County.

Marysville — New health commissioner for Union, Delaware, Madison and Morrow Counties is Dr. James P. Owen, of Cincinnati, succeeding Dr. Robert Vogel, who resigned to take a smiliar post in Montgomery County.

Toledo—Riverside Hospital's 75th anniversary was observed with a four-day celebration in June.

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"Premarin" with Meprobamate new potency

Each tablet contains 0.4 mg. "Premarin," 200 mg. meprobamate

**For undue emotional stress
in the menopause**

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PMB-200
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in each tablet).*

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salicylate benefits with minimal salicylate drawbacks

Rapid and prolonged relief — with less intolerance. The analgesic and specific anti-inflammatory action of BUFFERIN helps reduce pain and joint edema—comfortably. BUFFERIN caused no gastric distress in 70 per cent of hospitalized arthritics with proved intolerance to aspirin. (Arthritics are at least 3 to 10 times as intolerant to straight aspirin as the general population.[1])

No sodium accumulation. Because BUFFERIN is sodium free, massive dosage for prolonged periods will not cause sodium accumulation or edema, even in cardiovascular cases.

Each *sodium-free* BUFFERIN tablet contains acetylsalicylic acid, 5 grains, and the antacids magnesium carbonate and aluminum glycinate.

Reference: 1. J.A.M.A. 158:386 (June 4) 1955.

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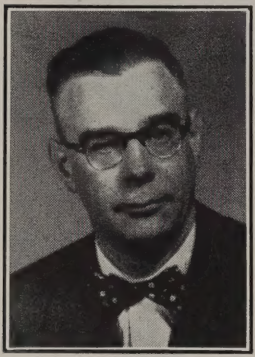
In Memoriam . . .

James R. Jarvis, M. D., Van Wert, who in April completed the maximum of three full terms as a member of The Council of the State Association, died on June 27 at the age of 52.

Dr. Jarvis served his entire professional career in the Van Wert area where he engaged in general practice and anesthesiology. He began practice in Van Wert in 1932 upon completion of an internship at White Cross Hospital, Columbus. A native of Mansfield, he received his B. A. degree from Ohio State University and graduated from the George Washington University Medical School in 1931. His contributions to the profession were statewide in several branches of medical organization work. As a member of The Council of the OSMA he worked in close liaison with County Medical Societies in the Third District. He was also chairman of the Advisory Committee to the Woman's Auxiliary.


J. R. Jarvis, M. D.

Long active in affairs of the Ohio Academy of General Practice, he served that organization as president and previously as director of the Third District. As a member of the Ohio Society of Anesthesiology he had been northwest district councilor, and on that organization's executive committee.

He was a past-president of the Van Wert Medical Society and served the local organization in many other capacities. Other professional affiliations included the executive committee of the Northwest Ohio Medical Association, the American Medical Association, the American Society of Anesthesiologists, the International Society of Anesthesiologists, the American Academy of General Practice, and Fellowship in the American College of Anesthesiology.

Dr. Jarvis took an active interest in municipal affairs and belonged to a variety of local organizations including the Presbyterian Church, the Masonic Lodge and the Chamber of Commerce. Surviving are his widow, three sons, a daughter, his parents and two brothers.

George W. Clark, M. D., Toledo; University of Michigan Medical School, 1900; aged 85; died June 16. Dr. Clark practiced in Toledo prior to World War I. After the war, during which he served with the Army Medical Corps, he moved to Defiance where he continued in practice until his retirement in 1940. He was a member of the Inverness Country Club, several Masonic bodies and the Kettering Golf Club in Defiance. Surviving is a daughter.

Allen H. Dunton, M. D., Cincinnati; University of Michigan Homeopathic Medical School, 1911; aged 70; died June 21; former member of the Ohio State Medical Association. Dr. Dunton retired from practice about five years ago after serving virtually all of his professional career in Cincinnati, with time out for military service during World War I. His widow survives.

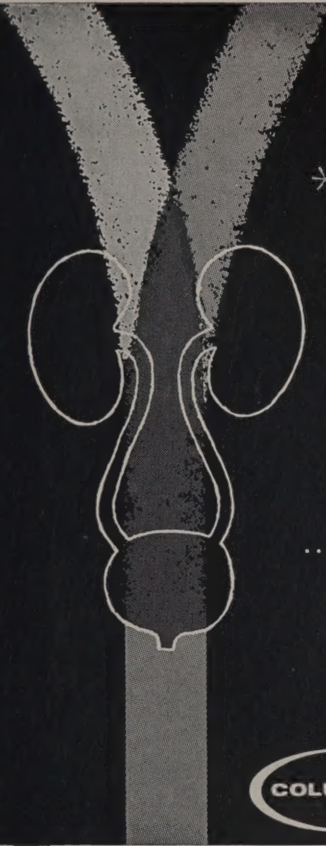
Paul M. Gordon, M. D., Cleveland; Western Reserve University School of Medicine, 1927; aged 55; died June 18; member of the Ohio State Medical Association and the American Medical Association. A native of Cleveland, Dr. Gordon practiced there since the completion of his medical training. He was a member of the Cleveland Yachting Club, several Masonic bodies, Phi Ro Sigma and Pi Sigma Alpha. Survivors include his widow, a son, a daughter, his mother and a sister.

Henry Jenkins, M. D., Cleveland; Toledo Medical College, 1902; aged 82; died March 31; former member of the Ohio State Medical Association. Dr. Jenkins was a practicing physician for many years in Cleveland.

Glendon E. Parry, M. D., Hillsboro; University of Cincinnati College of Medicine, 1951; aged 35; died June 18 in a traffic accident; member of the Ohio State Medical Association and the American Academy of General Practice and recent member of the American Medical Association. Dr. Parry had been a practicing physician in Hillsbor for four years. A veteran of World War II, he was a member of the local Rotary Club and Presbyterian Church. Survivors include his widow and his parents.

Ivah J. Ransbottom, M. D., Coldwater; Cincinnati College of Medicine and Surgery, 1892; aged 88; died June 20. Dr. Ransbottom practiced for many years in Celina and vicinity. He was a veteran of the Spanish-American War and World War I and served also in the Panama Canal Zone. Affiliations included memberships in several Masonic bodies and the Lutheran Church. A son with whom he resided survives.

Joseph Louis Ransohoff, M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1904; aged



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LOCALIZED MUCOSAL ANALGESIA

Phenylazo-diamino-pyridine HCl—acts solely on the urogenital mucosa; provides prompt relief from burning, pain and frequency.

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Sulfacetamide—eliminates mixed infections rapidly because of its unusual solubility in acid urine common to bacterial invasion of the urinary tract. No renal damage, concretions or anuria.

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—the dual activity of SULFID with the well-known antispasmodic effect of natural belladonna alkaloids.

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COLUMBUS PHARMACAL COMPANY COLUMBUS 16, OHIO

For Real Pain ...give real relief:

A.P.C. WITH Demerol® tablets

Each tablet contains:

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Caffeine	30 mg.	(½ grain)
Demerol hydrochloride	30 mg.	(½ grain)

Average Dose:

1 or 2 tablets.

Narcotic blank required.

Potentiated Pain Relief

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78; died June 17; member of the Ohio State Medical Association, the American Medical Association, the Western Surgical Association; Fellow of the American College of Surgeons; diplomate of the American Board of Surgery. Dr. Ransohoff retired in 1950 after an active practice during which he was professor of surgery at the University of Cincinnati. His appointments included those as director of surgical services at Jewish Hospital and as director of its cancer clinic. A major in the Medical Corps during World War I, he was a member of the Queen City Club, the Losantiville Country Club and the Rockdale Synagogue. Surviving are his widow; two daughters; a son, Dr. Joseph Ransohoff of New York City; a step-daughter and three sisters.

A. W. Sage, M. D., San Jose, California; University of Western Ontario Faculty of Medicine, Canada, 1904; aged 76; died June 14; member of the Ohio State Medical Association and the American Medical Association. Dr. Sage practiced in Kenton some 15 years before he moved to California about nine months ago. Surviving are his widow, a son with whom he made his home in California and a daughter.

Frank E. Sexton, M. D., Shaker Heights; University of Wooster, Medical Department, Cleveland, 1909; aged 75; died June 30; former member of the Ohio State Medical Association. A native of the Cleveland area, Dr. Sexton practiced there for more than 40 years. For many years he was chief of the medical staff of St. Ann's Hospital. A veteran of World War I, he was a member of Phi Beta Pi, the Catholic Church and the Catholic Physicians Guild. Surviving are his widow, two sons and two daughters.

Walter H. Sisson, M. D., Portsmouth; University of Vermont College of Medicine, 1915; aged 67; died June 28; member of the Ohio State Medical Association, the American Medical Association and the Industrial Medical Association. Dr. Sisson practiced for about 30 years in Portsmouth where he also was surgeon for the Detroit Steel Corp., Portsmouth Division. For several years he was director of the Portsmouth General Hospital Auxiliary Charity Horse Show. Affiliations included memberships in the Presbyterian Church and several Masonic bodies. Survivors include his widow, two daughters and a sister.

Sherman C. Ward, M. D., Lorain; University of Michigan Medical School, 1915; aged 66; died June 29; recent member of the Ohio State Medical Association. Dr. Ward practiced medicine for 43 years in Lorain and vicinity and served for many years as Lorain County coroner. Affiliations included memberships in the Ohio State Coroners Association, the National Coroners Association, the Methodist Church, several Masonic bodies, the Kiwanis Club, Eagles and Elks Lodges. Surviving are his widow, four sons and two stepchildren.

Guernsey County Resolution Honors Former Quaker City Physician

The following resolution was made a part of the minutes of the Guernsey County Medical Society:

"Dr. Manley S. Lawrence was born March 22, 1876 at Canton, Pa., the son of W. T. and Julia Spaulding Lawrence. He was graduated from Hiram College in 1900 and from Ohio Medical University (O.S.U.) in 1903. He practiced for the last 45 years of his life in Quaker City, O., and died Nov. 21, 1957 at the home of his daughter in Cambridge, O.

"WHEREAS: Dr. Manley S. Lawrence was a loved and highly respected member of the Guernsey County Medical Society who embodied all the wisdom, kindliness, gentleness and patience of the old-fashioned family doctor during the 54 years he spent in the practice of medicine, never failing to put the welfare of his patients first in all his endeavors.

"AND WHEREAS: Dr. Lawrence participated actively in all forward-looking projects in the communities which he served, helping in many ways to shape the course of religious, economic, educational and social progress. He also took an active part in affairs of the County Medical Society, and during his earlier residence in Noble County was one of the charter members of the medical organization which for a time existed there.

"AND WHEREAS: At the time of his graduation from medical school he was married to Miss Nella Shriver and with her established a home in which perfect companionship and loving parenthood were deftly combined and continuously enjoyed, thus setting for all their friends and neighbors an admirable example of happy American family life.

"THEREFORE BE IT RESOLVED by the members of the Guernsey County Medical Society that Dr. Lawrence was a cherished friend and respected colleague in whose passing they share a feeling of great loss with his wife and family, and they extend their deepest sympathy.

"FURTHER BE IT RESOLVED that a copy of these resolutions be spread on the minutes of the proceedings of the Guernsey County Medical Society, with additional copies to his wife, and to the *Ohio State Medical Journal* for publication therein.

"Respectfully submitted by the
Committee on Resolutions."

(Signed) C. A. Craig, M. D.
Wm. Camp, M. D.
James Toland, M. D.

Grant Promotes Birthmark Study By Columbus Physicians

A team of Franklin County physicians will conduct a "study of hemangiomatous tumors of early childhood," as the result of a grant of $4550 toward that project by the American Cancer Society.

Principal investigators are Dr. John C. Trabue, Dr. H. William Clathworthy, Jr., and Dr. James R. Lloyd. Others in the study group are Dr. Thomas E. Shaffer, Dr. Arthur G. James, Dr. Ben Kirkendall, Dr. Eldred B. Heisel and Dr. Thomas Pomeroy.

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NEW AMBAR #2
EXTENTABS
(METHAMPHETAMINE 15 mg., PHENOBARBITAL 1 gr.)
for patients who
require higher
methamphetamine
dosage

Activities of County Societies . . .

First District

(COUNCILOR: CHARLES W. HOYT, M. D., CINCINNATI)

CLINTON

Members of the Clinton County Medical Society held a brief business session at the monthly luncheon meeting at the General Denver Hotel Tuesday (July 1). A guest was Bob Davies, medical student who is a member of the Ohio preceptorship program. He was with Dr. Edmund Yantes and the others had the opportunity of talking with him about the program following the meeting.

Injections to prevent rabies were one of the topics since there have been several instances of rabid animals recently and a standard charge for all doctors to make was agreed on.

Dr. Yantes reported on social security and Dr. R. R. Buchanan on the progress of the health survey being made by the Clinton County Health Council.

Second District

(COUNCILOR: R. DEAN DOOLEY, M. D., DAYTON)

MIAMI

Medical problems in connection with the county-wide Civil Defense organization were discussed at the regular meeting of the Miami County Medical Society on June 6. Physicians were joined by the administrative and nursing supervisors of the county's three hospitals.

Dr. George Upton, medical director of the Miami County Civil Defense organization, presented a brief talk. Remarks were also made by V. R. Baker, county Civil Defense chief.

Emergency surgical teams were appointed for each hospital in the county. The Society also agreed to sponsor a demonstration Civil Defense hospital field unit at the county fair if such a unit becomes available.

MONTGOMERY

A special meeting of the Montgomery County Medical Society was held on June 12. There were 135 persons present. Dr. A. V. Black, president, called the meeting to order. "Purpose of the meeting: To consider recommendation of the MCMS Executive Council that the Society endorse and actively promote the establishment of a Medical School in Dayton."

Early in April the Ohio Commission on Education Beyond the High School recommended the establishment of a fourth medical school in Ohio. Three possible sites for such a school were mentioned, among them, Dayton.

After discussion, the motion passed "that the Society endorse and actively promote the establishment of a medical school in Dayton."

Fifth District

(COUNCILOR: GEORGE W. PETZNICK, M. D., CLEVELAND)

ASHTABULA

Members of the Ashtabula County Medical Society and the Ashtabula County Bar Association with their wives met on June 7 at the Swallows Restaurant for a program and dinner.

Speaker for the occasion was Sherlock Holmes Evans, Massillon attorney, author and actor. Dr. Walter Brown, Conneaut, president of the Medical Society, spoke for physicians and Walter Barsky, president of the Bar Association, for the attorneys.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

COLUMBIANA

Dr. James Krieger, chief of the Division of Gynecology, Cleveland Clinic, was guest speaker at a dinner meeting of the Columbiana County Medical Society on June 10 in the Hotel Wick at Lisbon. His subject was "Uterine Malignancy."

MAHONING

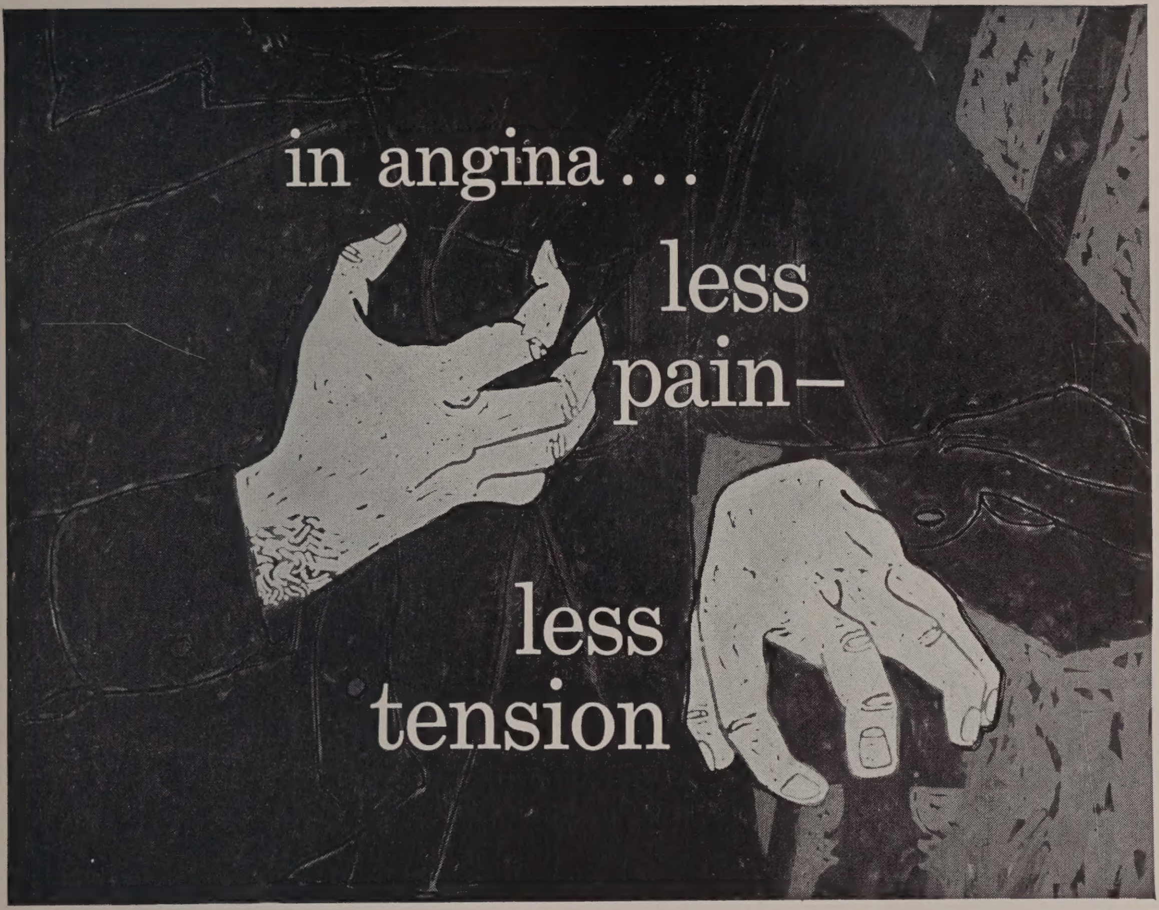
A panel of five physicians from Ohio State University's School of Medicine reported on heart research at a meeting of the Mahoning County Medical Society Tuesday night (June 18) at Squaw Creek Country Club.

Dr. Charles A. Doan, dean of the college, was moderator, before some 125 district physicians. The physicians reported on heart research conducted under the auspices of the Bremer Foundation, established by the will of the late Richard P. Bremer, prominent Youngstown businessman who died in 1953. The Bremer Foundation set aside funds for the advancement of medicine and surgery, especially in the field of heart disease.

Dr. Doan said that the foundation funds had contributed toward making the Ohio medical college one of the finest in the nation.

Each physician on the panel discussed a phase of heart research.

Dr. Eric Ogden, professor and chairman, de-



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1. Russek, H. I.: Postgrad. Med. *19*:562 (June) 1956.

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CARTRAX should be taken 30 to 60 minutes *before* meals, on a continuous dosage schedule. Use PETN preparations with caution in glaucoma.

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*Trademark

partment of physiology discussed pressure studies on dog hearts.

Dr. H. Paul Pieper, research professor, department of physiology, discussed an electronic device he has perfected which measures the relationship of pressures in the heart chambers with various heart diseases.

Dr. Nicholas Vorys, instructor, discussed research into maternity fatalities.

Dr. Howard D. Sirak, assistant professor, department of surgery, discussed open heart surgery.

Dr. Andrew Detesco, president of the county medical group, presided at the session.—*Youngstown Vindicator.*

TRUMBULL

The following notes were compiled from the Trumbull County Medical Society Bulletin of June 11 which contained a number of items on medical topics of current local interest as well as organization information.

A huge turnout made doctors' donor day for the American Red Cross program at the Trumbull Memorial Hospital on June 6 a great success. Of the 140 persons who donated blood, 24 were doctors. Others were doctors' assistants, members of their families, etc.

Seven members were listed as giving talks before local lay organizations.

Dr. Edward Marshall, Cleveland, gave a talk on "Differential Diagnosis of Acute Abdominal Pain" to the Trumbull County Chapter of the American Academy of General Practice on June 4.

The Trumbull County Medical Society accepted a proposal by the Trumbull County Tuberculosis and Health Association to conduct a six-months trial program in an effort to detect diabetes in unsuspecting persons. Under the plan each person getting an x-ray will be given one of the diabetic Drypak kits.

The Board of Trustees of the Trumbull Memorial Hospital had as guests the staff members of the hospital at Rappold's on June 25 with a late afternoon meeting followed by dinner. This is an annual affair.

Seventh District

(COUNCILOR: ROBERT HOPKINS, M. D., COSHOCTON)

BELMONT

The Belmont County Medical Society and Auxiliary met at the Belmont Hills Country Club on June 19 for a program and dinner. Speaker was Dr. Daniel W. Dickinson, of the Wheeling Clinic, who discussed the topic, "Tumors of the Lungs."

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

SCIOTO

Dr. Howard Sirak, associate professor and chief of the Division of Cardiovascular Surgery, Ohio State University, was speaker at the July 14 meeting of the Scioto County Medical Society in Portsmouth. His subject was "Open Heart Surgery."

Just prior to the regular meeting, the local Cancer Society sponsored the showing of the film "Uterine Cancer, The Problem of Early Diagnosis." The showing was for preview by physicians pending its showing to lay groups.

RICHLAND

The fifth annual combined professional men's golf meeting, under the sponsorship of the Richland County Medical Society, was held at the Westbrook Country Club in Mansfield on June 19, 1958, with physicians, veterinarians, dentists, pharmacists, and attorneys in attendance. After an afternoon of golf a dinner meeting was held. Members of the various professions are looking forward to the meeting next year.—John J. Clark, M. D., Secretary.

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Activities of Woman's Auxiliary . . .

CHAIRMAN PUBLICITY COMMITTEE—Mrs. W. J. Horger,
1100 Ohio Ave., East Liverpool, Ohio
(See Page 997 for roster of officers.)

SCIOTO COUNTY

To exchange ideas, discuss mutual interests and acquaint each other with the workings of the respective groups, wives of Scioto County doctors, dentists, lawyers and pharmacists gathered at the Elks Country Club for a luncheon and afternoon program sponsored by the Woman's Auxiliary to Scioto County Medical Society, under the leadership of its president, Mrs. Armin A. Melior. Ninety women were present.

Mrs. Melior welcomed the group and expressed the hope that special projects for the good of the community could be accomplished by the combined efforts of the women. Mrs. Melior also pointed out the importance of becoming better acquainted with the individual women in each of the organizations.

By way of the workshop type program, the medical Auxiliary presented briefings on its functions and projects. Mrs. Clyde M. Fitch discussed the nurse recruitment endeavors of the auxiliary. Mrs. Samuel L. Meltzer, State auxiliary chairman of credits and awards, and Mrs. William Hugenberg gave a "repeat performance" of a Health Reporter radio interview which had recently been given over Station WPAY on the nation's medical schools and Medical Education Week. Mrs. A. L. Berndt, president-elect, explained the family health record and the wallet cards, copies of which were distributed. Mrs. W. A. Ray talked on the American Medical Association magazine, *Today's Health*. The American Education Foundation Fund of the AMA also was discussed.

Mrs. Hugenberg who is the immediate past president, was presented with a past president's pin by Mrs. Melior on behalf of the auxiliary.

The president then introduced Mrs. George W. Cooper of Waverly, Ohio, who is 9th district director of medical auxiliaries in this area.

The entertainment featured a "Geisha Girl Revue" staged by members of Twig 6 of Mercy Hospital Guild. Mrs. B. U. Howland served as mistress of ceremonies.

Bridge and canasta concluded the afternoon's entertainment.

TRUMBULL COUNTY

On May 15, the Trumbull County Medical Auxiliary met for tea at the home of the outgoing President, Mrs. Clyde Muter. The new officers for the coming year were installed by the immediate-past State President, Mrs. V. R. Frederick. Mrs. Muter gave special recognition to those who had served on her committees this past year. Mrs. James Williams and Mrs. George Mokris served as co-hostesses for this meeting. On May 21, the doctors entertained their wives at a dinner meeting at the Trumbull Country Club.

During the month of May the auxiliary members distributed posters throughout the Warren area calling attention to the importance of everyone having polio shots. On May 26, 27, and 28 they helped the school nurses give the third polio shot to school children who had not already been to their family physician.

On June 5 and 6 the Trumbull Medical Society sponsored the visit of the Red Cross bloodmobile to Warren and Niles. Auxiliary members, hospital personnel, and doctors, donated blood. Auxiliary members also helped serve coffee and doughnuts to its blood donors.

Supreme Court Rules Against FTC on Insurance

The Federal Trade Commission has lost ground in its campaign against accident and health insurance advertising. The Supreme Court in a unanimous decision held that FTC has no jurisdiction over such advertising in states that have their own laws on the subject—even though such laws are not being enforced.

Cases on the subject had been appealed by the American Life Convention, the Life Insurance Association of America and the Health Insurance Association of America.

The law authorizes federal regulation in this area only where states have not entered the field. FTC argued that in this instance the states with regulatory laws were not applying them.

The court pointed out that the states in question have prohibitory legislation and that failure on their part to enforce it was not sufficient ground to use federal law.

New York Academy Program

The New York Academy of Medicine will hold its second annual postgraduate week (formerly the Graduate Fortnight) October 13-17. As last year, the title of the program is "Research Contributions to Clinical Practice." Details may be obtained by addressing the Academy at 2 East 103rd Street, New York 29, N. Y.

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*Chappel, C.C., J.A.M.A., 162: 1414, (Dec. 8) 1956

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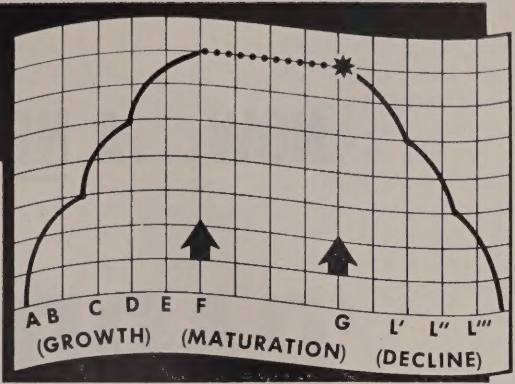

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Riseman, J. E. F., Altman, G. E., and Koretsky, S.:
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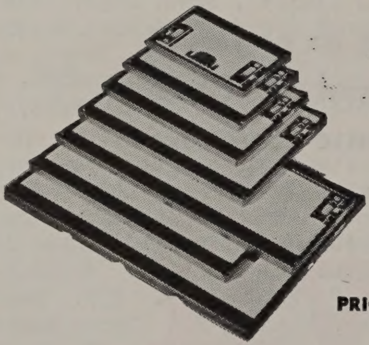

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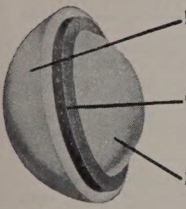

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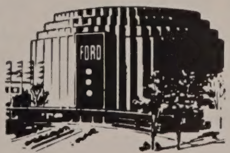

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COMING MEETINGS

Ohio State Medical Association, 1959 Annual Meeting, April 21-24, Columbus.

American Medical Association, Clinical Session, December 2-5, Minneapolis, Minn.

AMA Public Relations Institute, Chicago, August 27-28.

American Association of Medical Assistants, Palmer House, Chicago, October 31-November 2.

Eighth Councilor District, Annual Medical Meeting, Zanesville Country Club, Zanesville, October 2.

Ohio Academy of General Practice, Annual Scientific Assembly, October 1-2, Toledo.

Sixth Councilor District, Postgraduate Day, October 22, Akron.

University of Cincinnati College of Medicine, Postgraduate Course in Heart Disease, Cincinnati, September 3-6.

West Virginia State Medical Association, Annual Meeting, White Sulphur Springs, W. Va., August 21-23.

General Practice Credit Announced For Cincinnati Heart Course

The University of Cincinnati has received notification from the American Academy of General Practice Regional Advisor, Commission on Education, that the seminar on Heart Disease—Current Concepts in Diagnosis and Treatment, to be given by the Cardiac Laboratory at the Cincinnati General Hospital, September 3-6, has been accepted for 24 hours of Category I credit.

Refer to July issue of *The Journal,* page 958, for the program.

Advance registration is requested. Tuition fee is $75. The course will be limited to the first 50 applicants. Applications should be sent to: Johnson McGuire, M. D., Cardiac Laboratory, B-4, Cincinnati General Hospital, Cincinnati 29.

Dr. Higgins Tours Russia and Other European Countries

Dr. Charles Higgins, head of the Urology Department at Cleveland Clinic, recently left for a 38-day professional tour of Sweden, Russia, England and various European countries. In his capacity as chairman of the board of governors of the American College of Surgeons, his schedule included a guided tour of Russian educational and public health facilities.

The tour included official appearances at the International Urological Congress in Stockholm, the Academy of Science in Vienna and the international meeting on cancer in London.

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Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 79 E. State St., Columbus 15. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed. or other physicians who are in need of associates.

NEW MEDICAL CENTER opening within 30 days in Solon, Ohio, fastest growing industrial area in the State. Desirable location for G. P., Pediatrician, Ophthalmologist, Radiologist and Surgeon. Contact Norton Norr, 2177 S. Taylor Rd., University Heights 18, Ohio. FA 1-0190.

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A Recent Opinion of the Attorney General

Following is the syllabus of a recent opinion given by Attorney General William Saxbe:

(1) If the estimated expenses of a general health district are in excess of revenue available within the ten-mill limitation, a special levy may be made pursuant to the provisions of Sec. 3709.29, R. C.

(2) A special levy for a general health district, imposed by a vote of the electors as provided in Sec. 3709.39, R. C., would have no application to taxable real property situated in a city receiving public health service from the general health district by contract, and such special levy should be submitted to the electors of the general health district only, which district would not include cities furnished public health service on such contract basis. Opinion No. 2294.

FOR SALE: Cement Block Building with Perma-Stone front, suitable for doctor's office and home; built 10 yrs. ago. Accredited hospital in city. Ideal for a general practitioner. Located in small but growing county seat in north-central Ohio. Contact Box 984, c/o Ohio State Medical Journal.

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Southwestern Ohioans View Weekly Medical Show on Television

A medical show for Southwestern Ohio television viewers is "It's Baby Time," which is sponsored every Thursday on WCPO-TV, Cincinnati, and every Wednesday on WLW-D, Dayton, by Hospital Care Corporation, the Blue Cross Plan for Southwestern Ohio.

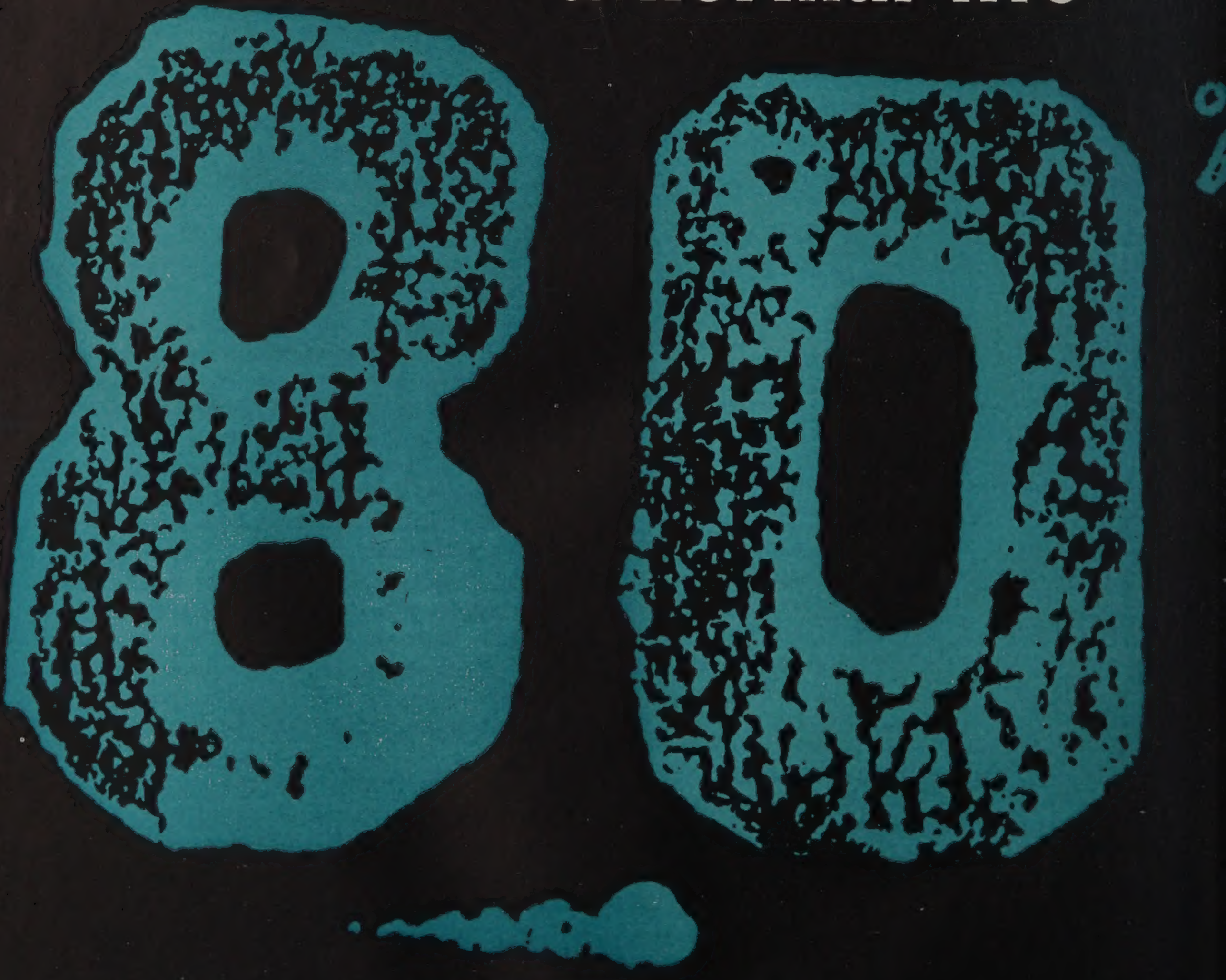
The 15-minute films, made with co-sponsorship of the Bureau of Health Education of the American Medical Association, features Dr. W. W. Bauer, AMA health director. Also featured is Jane Warren, a registered nurse. They discuss care, feeding and growth patterns of babies—allaying fears, assisting new mothers, building a greater confidence in what modern medicine is doing and can do for both mother and baby.

Blue Cross messages during the 15-minute period also point out the better hospital-medical care available today and explain why it costs what it does. Furthermore, the messages discuss the longer life span enjoyed today, the greater percentage of babies born in hospitals, and the many techniques and procedures that are helping the American people to live longer, healthier lives.

Time for the telecasts is 10:15 a. m. in each city. They began April 2 and will continue through September 30.

The 15th Annual Meeting of the American Medical Writers' Association will be held at the Hotel Morrison, Chicago, September 26.

"80% of epileptics... can, with appropriate care and encouragement, lead a normal life"*



* Lord Cohen of Birkenhead: *British M.J.* 1:672, 1958.

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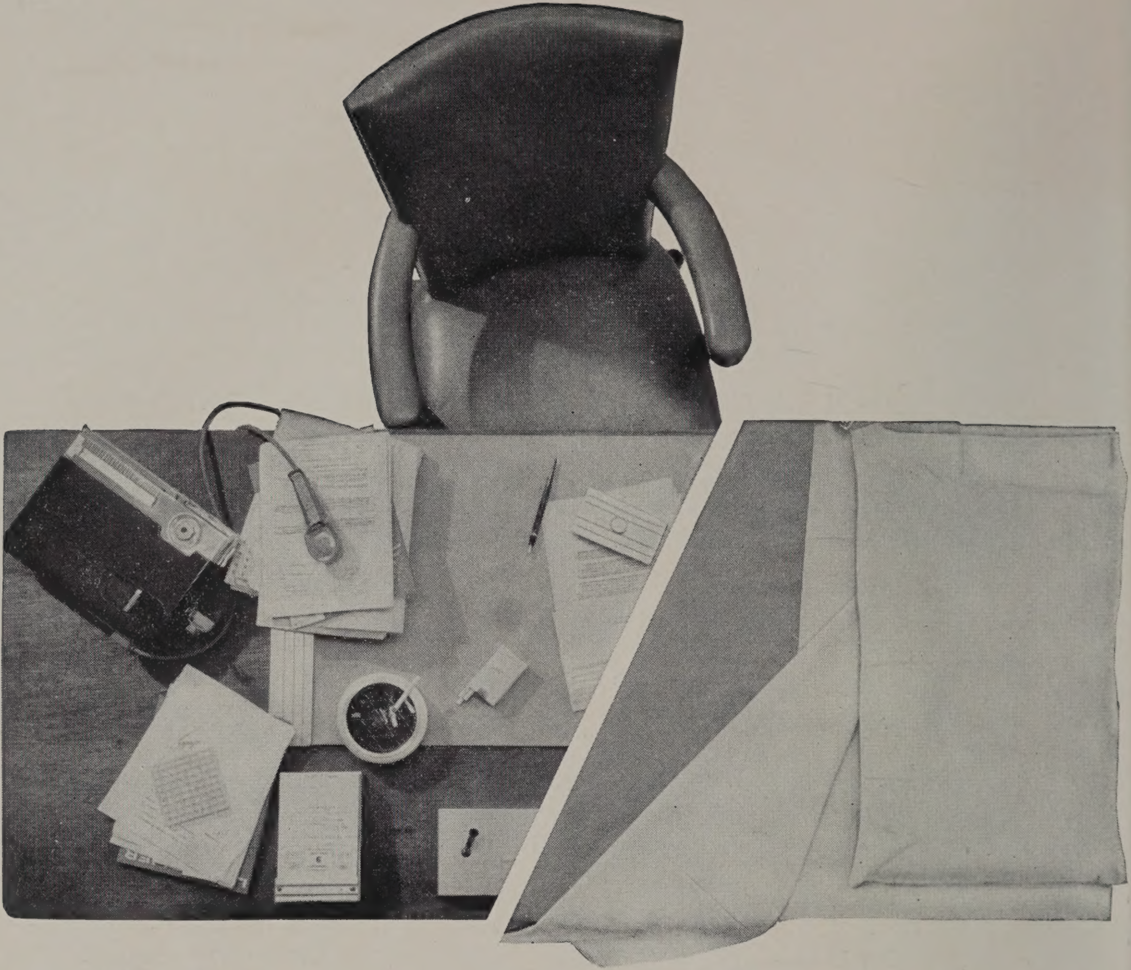

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The Ohio State Medical Journal

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(1) Hagedorn, A. B.: Proc. Staff Meet. Mayo Clin. 32:705 (Dec. 11) 1957.
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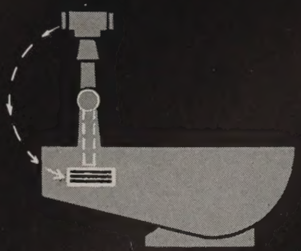

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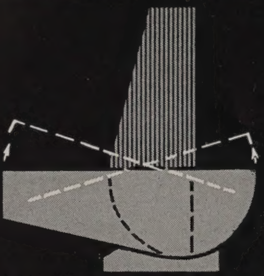

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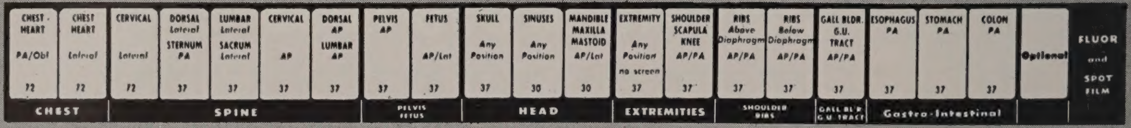
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ASHTABULA—Walter J. Brown, President, Conneaut; Robert J. Zimmerman, Secretary, Conneaut. 2nd Tuesday, monthly.

CUYAHOGA—Thomas D. Kinney, President, Cleveland; Mr. Robert A. Lang, Executive Secretary, 2009 Adelbert Road, Cleveland 6. 2nd Tuesday, monthly.

GEAUGA—Hubert E. Shafer, President, Middlefield; Alton W. Behm, Secretary, Chardon. 2nd Friday, monthly.

LAKE—Robert A. Irvin, President, Painesville; Mrs. Owen A. McLaren, Executive Secretary, 1051 Cadle Avenue, Mentor. 2nd Tuesday, monthly, except July and August.

SIXTH DISTRICT

COLUMBIANA—Roy C. Costello, President, East Liverpool; William J. Horger, Secretary, East Liverpool.

MAHONING—Andrew A. Detesco, President, Youngstown; Mr. Howard C. Rempes, Jr., Executive Secretary, 125 Commerce Street, Youngstown 3. 3rd Tuesday, monthly, except July and August.

PORTAGE—Rufus P. McCormick, President, Ravenna; Don P. VanDyke, Secretary, Kent. 3rd Tuesday, monthly.

STARK—Roy H. Clunk, President, Massillon; Mr. E. M. Sprunger, Executive Secretary, 405 Fourth Street, Canton 2. 2nd Thursday, monthly.

SUMMIT—Arthur Dobkin, President, Akron; Mr. Sidney H. Mountcastle, Executive Secretary, 437 Second National Building, Akron 8. 1st Tuesday, monthly, September through June.

TRUMBULL—Aubrey L. Sparks, President, Warren; Charles M. Stone, Secretary, Warren. 3rd Wednesday, monthly.

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COSHOCTON—Glenn W. Stelzner, President, Coshocton; Harold W. Lear, Secretary, Coshocton. 2nd Tuesday, monthly.

HARRISON—George E. Henderson, President, New Athens; Gerald E. Vornies, Secretary, Scio. Meetings quarterly.

JEFFERSON—Carl F. Goll, President, Steubenville; Frances J. Shaffer, Secretary, Toronto. 3rd Tuesday, monthly.

MONROE—Byron Gillespie, Secretary, Woodsfield.

TUSCARAWAS—William C. Roche, President, Gnadenhutten; Arthur J. Stevenson, Secretary, New Philadelphia. 2nd Thursday, monthly.

EIGHTH DISTRICT

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FAIRFIELD—Fred Spangler, President, Lancaster; Arthur B. VanGundy, Secretary, Lancaster. 2nd Tuesday, monthly.

GUERNSEY—Howard D. Miller, President, Cambridge; Thomas D. Swan, Secretary, Cambridge. 1st Thursday, monthly.

LICKING—John E. Hendricks, President, Newark; William J. Kennedy, Secretary, Newark. Last Tuesday, monthly.

MORGAN—A. H. Whitacre, President, Chesterhill; C. E. Northrup, Secretary, McConnelsville. Called Meetings.

MUSKINGUM—Louis P. Cassady, President, East Fultonham; William A. Knapp, Secretary, Zanesville. 1st Tuesday, monthly.

NOBLE—Norman S. Reed, President, Caldwell; E. G. Ditch, Secretary, Caldwell. 1st Tuesday, monthly.

PERRY—Joseph H. Clouse, President, Somerset; O. D. Ball, Secretary, New Lexington. Called meetings.

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NINTH DISTRICT

GALLIA—Ralph B. Burner, President, Gallipolis; George E. Files, Secretary, Gallipolis. Last Thursday, monthly.

HOCKING—Howard M. Boocks, President, Logan; Richard C. Jones, Secretary, Logan.

JACKSON—Louis J. Jindra, President, Oak Hill; Brinton J. Allison, Secretary, Oak Hill.

LAWRENCE—Harry Nenni, President, Ironton; George Newton Spears, Secretary, Ironton. 2nd Tuesday, monthly.

MEIGS—Joseph J. Davis, President, Middleport; Charles J. Mullen, Secretary, Pomeroy.

PIKE—Robert M. Andre, President, Waverly; Mack E. Moore, Secretary, Piketon. 1st Tuesday, monthly.

SCIOTO—Samuel L. Meltzer, President, Portsmouth; Carl H. Laestar, Secretary, Portsmouth. Second Monday, monthly.

VINTON—Richard E. Bullock, President, McArthur; H. D. Chamberlain, Secretary, McArthur.

TENTH DISTRICT

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FAYETTE—Robert U. Anderson, President, Washington C. H.; Philip E. Binzel, Secretary, Washington C H. 2nd Tuesday, monthly.

FRANKLIN—Robert M. Inglis, President, Columbus; Mr. William Webb, Jr., Executive Secretary, 79 East State Street, Columbus 15. Meetings in January, April, June, November and December.

KNOX—James C. McLarnan, President, Mount Vernon; Clinton W. Trott, Secretary, Mount Vernon. Quarterly meetings.

MADISON—William T. Bacon, President, London; Paul G. H. Wolber, Secretary, London. 2nd Wednesday, monthly.

MORROW—Francis W. Kubbs, President, Mt. Gilead; Frank H. Sweeney, Secretary, Mt. Gilead. 1st Tuesday, monthly.

PICKAWAY—Frank R. Moore, President, Circleville; E. L. Montgomery, Secretary, Circleville. 1st Friday, monthly.

ROSS—Lewis W. Coppel, President, Chillicothe; William M. Garrett, Secretary, Chillicothe. 1st Thursday, monthly.

UNION—Paul Richard Zaugg, President, Marysville; May B. Zaugg, Secretary, Marysville. 2nd Tuesday, monthly.

ELEVENTH DISTRICT

ASHLAND—Harold V. Marley, President, Ashland; Myron A. Shilling, Secretary, Ashland. 1st Friday, monthly.

ERIE—William E. Birmingham, President, Sandusky; Edward Gillette, Secretary, Sandusky. Last Thursday, monthly.

HOLMES—Luther W. High, President, Millersburg; Owen F. Patterson, Secretary, Millersburg. 2nd Wednesday.

HURON—Owen J. Nicholson, President, Norwalk; John V. Emery, Secretary, Willard. 2nd Wednesday, March, June, September and December.

LORAIN—Ben V. Myers, President, Elyria; Lawrence C. Meredith, Secretary, Elyria; Mrs. Ruth Zealley, Executive Secretary, 311 Elyria Block, Elyria. 2nd Tuesday, monthly.

MEDINA—William G. Halley, President, Lodi; E. A. Ernst, Secretary, Lodi. 3rd Thursday, monthly.

RICHLAND—Charles F. Curtiss, President, Bellville; Harlin G. Knierim, Acting Secretary, Mansfield.

WAYNE—James E. Robertson, President, Wooster; R. E. Schulz, Secretary, Wooster. 2nd Wednesday, monthly.

THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

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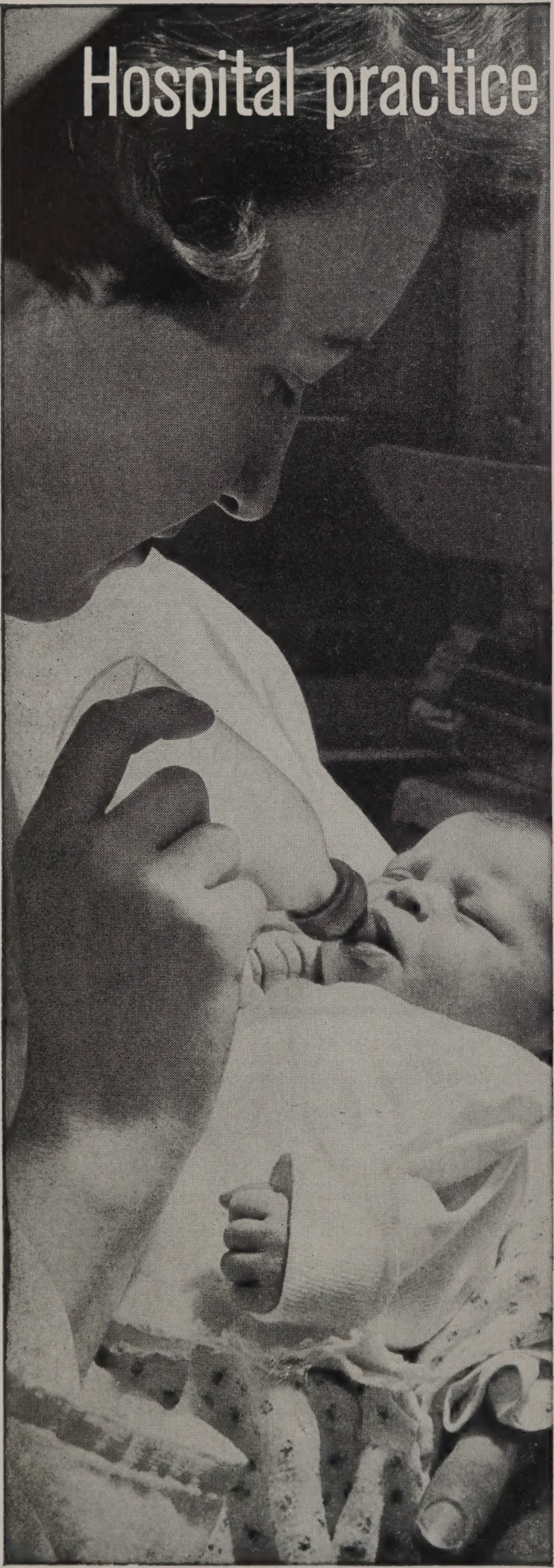
Hospital practice of infant feeding



Standard one-formula mixture

Normal infant nutrition requires approximately 50 calories per pound of weight. Caloric distribution should be about 15% from protein, 50% from carbohydrates and 35% from fat as formulated for the mixtures in the tables below.

For young infants, a favorable hospital formula consists of a milk and Karo Syrup mixture, isocaloric with human milk, e.g. 20 calories per ounce.

WHOLE MILK FORMULA

FORMULA	OZ.	TOTAL CALORIES	CARB. CAL.	FAT CAL.	PROT. CAL.
Whole milk	24	480	5%	36%	14%
Water	22	—	—	—	—
Karo Syrup	1½	180	45%	—	—

EVAPORATED MILK FORMULA

FORMULA	OZ.	TOTAL CALORIES	CARB. CAL.	FAT CAL.	PROT. CAL.
Evaporated milk	11	484	5%	36%	14%
Water	22	—	—	—	—
Karo Syrup	1½	180	45%	—	—

An infant will usually take 2 to 3 ounces more than his *age in months* at 3 to 4 hour intervals to satisfy his appetite and nutritional needs. It is psychologically unwise to force prescribed amounts. Normally, the gain in weight of 6 to 8 ounces a week during the earlier months gradually diminishes to 3 to 4 ounces a week by the end of the first year. The standard one-formula mixture not only provides adequate nutrition when vitamin supplements are added; it also provides educational opportunities to prevent feeding problems.

ADVANTAGES OF KARO® SYRUP IN INFANT FEEDING

Composition: Karo Syrup is a superior dextrin-maltose-dextrose mixture because the dextrins are nonfermentable and the maltose is rapidly transformed into dextrose which requires no digestion.

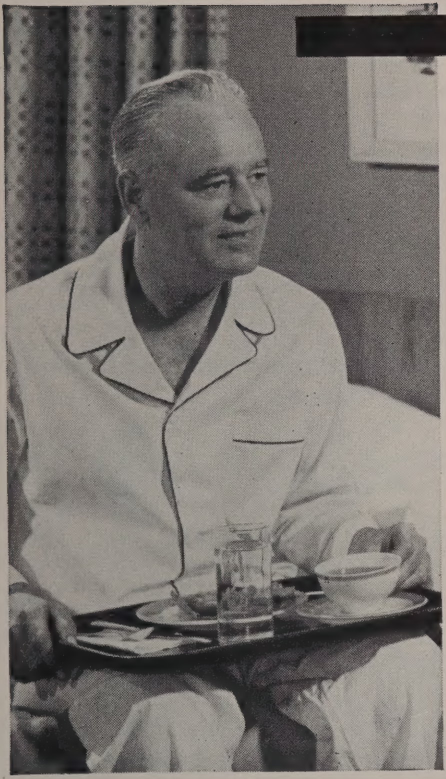
Concentration: Volume for volume Karo Syrup furnishes twice as many calories as similar milk modifiers in powdered form.

Purity: Karo Syrup is processed at sterilizing temperatures, sealed for complete hygienic protection and devoid of pathogenic organisms.

Low Cost: Karo Syrup costs 1/5 as much as expensive milk modifiers and is available at all food stores.

Free to Physicians—Book of Infant Feeding Formulas with convenient schedule pads. Write: Karo Infant Feeding Guide, Box 280, New York 46, N. Y.

CORN PRODUCTS REFINING COMPANY



IN DEBILITATING DISEASE

Patients receiving NILEVAR®

Eat more...
Feel better...
Recover faster

Compared to control patients, those receiving Nilevar (brand of norethandrolone) have repeatedly demonstrated more rapid and more complete recovery from serious acute illness and increased comfort and well-being in chronic illness.

A multitude of case histories are now adding individual clinical color to the earlier controlled investigations which defined the actions of Nilevar as an effective aid in reversing negative nitrogen balance and in building protein tissue.

In typical case reports such gratifying comments as these appear:

Underweight —"Appetite considerably increased within one week. Sense of well-being and vigor increased along with increased appetite."

Prematurity (Birth weight: 2 pounds, 4 ounces) — "Gradual improvement in appetite and capacity for formula. . . . Excellent progress and weight gain for a very immature infant."

Carcinoma of the Uterus —"Within four days appetite became excellent, took full diet. . . . More ambition while on Nilevar. Enjoys life. Takes part in church and other social affairs."

Third Degree Burn —". . . soon began eating all that was offered. . . . Began to show signs of hope for recovery. . . . Perhaps one of the greatest changes was in the appearance of his wounds which were so very much improved."

The dosage for adults is 20 to 30 mg. daily in single courses no longer than three months. For children the daily dosage is 0.5 mg. per kilogram of body weight, in single courses no longer than three months.

Nilevar is supplied in tablets of 10 mg. and ampuls of 25 mg. (1 cc.).

G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

SEARLE

Faster rehabilitation i

Joint inflammation and muscle spasm are the two elements most responsible for disability in rheumatic-arthritic disorders—and MEPROLONE is the one agent that treats both.

MEPROLONE suppresses the inflammatory process and simultaneously relieves aching and stiffness caused by muscle spasm, to provide greater therapeutic benefits and a shorter rehabilitation period than any single antirheumatic-antiarthritic agent.

MEPROLONE-2 is indicated in cases of severe involvement, yet often leads to a reduction of steroid dosage because of its muscle-relaxant action. When involvement is only moderately severe or mild, MEPROLONE-1 may be indicated.

SUPPLIED: Multiple Compressed Tablets in three formulas: MEPROLONE-2—2.0 mg. prednisolone, 200 mg. meprobamate and 200 mg. dried aluminum hydroxide gel (bottles of 100). MEPROLONE-1 supplies 1.0 mg. prednisolone in the same formula as MEPROLONE-2 (bottles of 100). MEPROLONE-5—5.0 mg. prednisolone, 400 mg. meprobamate and 200 mg. dried aluminum hydroxide gel (bottles of 30).

a

Because muscles move joints, both muscle spasm and joint inflammation must be considered in treating the rheumatic-arthritic patient . . .

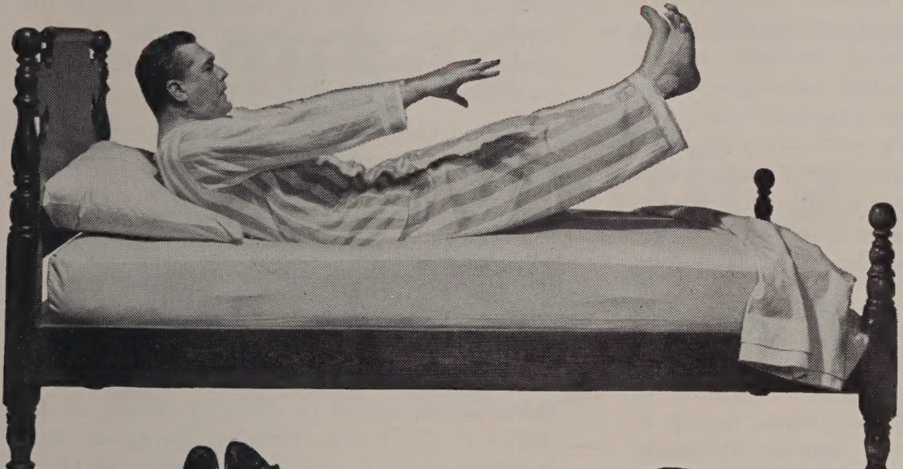
MERCK SHARP & DOHME Division of MERCK & CO., INC., Philadelphia 1, Pa. MSD

Rheumatoid Arthritis

multiple compressed tablets

MEPROLONE®

E FIRST MEPROBAMATE-PREDNISOLONE THERAPY



b

MEPROLONE is the one antirheumatic-antiarthritic that exerts a simultaneous action to relax muscles in spasm and to suppress joint inflammation . . .

c

Therefore, MEPROLONE does more than any single agent to help the physician shorten the time between disability and employability.

MEPROLONE is a trade-mark of Merck & Co., Inc.

The Physician's Bookshelf

By JONATHAN FORMAN, M. D.

Physiopathology of the Reticulo-Endothelial System, by B. N. Halpern. A Symposium organized by The Council for International Organizations of Medical Sciences, established under UNESCO. ($9.00, *C. C. Thomas Publisher, Springfield, Ill.)* It was the aim of the symposium to bring together distinguished investigators belonging to various disciplines in order to compare and discuss results obtained in this field. Three important functions were particularly studied, namely the phagocytic activity, the metabolic function, and the role of the reticulo-endothelial system in the defense against bacterial infection. The importance of this group of cells in this system in maintaining physiological harmony and in defending the organism against pathological states was stressed throughout the symposium which provides the most up-to-date and authoritative account of the subject suitable. Dr. Charles Austin Doan of Columbus was one of the participants in the symposium. This is a book that all interested in defense mechanisms of the human body must read.

The Pathogenesis of Coronary Occlusion, by A. D. Morgan, M. D. ($8.50, *C. C. Thomas Publisher, Springfield, Ill.)* The annual number of deaths due to coronary occlusion shows no sign of decreasing. In the course of 1949 to 1952 deaths from this cause in England and Wales increased by 30 per cent as compared with 6 per cent in cases of malignant disease. In 1952 alone coronary disease was responsible for 40,000 deaths there, and in 1955 this figure had increased to over 70,000. This book provides a critical and constructive examination of Professor J. B. Duguid's thrombogenic hypothesis from the viewpoint of coronary disease. Basing his study on the large number of cases which he has examined either personally or through the records, he analyzes the cause of death in each case and gives the details of his own results. The adoption of this theory must inevitably modify the present approach to etiology and treatment; therefore it is an extremely important book for all who deal with patients having this, or threatened with this disease.

Microbial Ecology: The Seventh Symposium of the Society for General Microbiology, by R. E. O. Williams and C. C. Spicer. ($6.50, *Cambridge University Press, New York 22, N. Y.)* The papers in this symposium summarize current knowledge and views on aspects of the ecology of micro-organisms. After an introduction, a group of papers considers the effects of environmental factors that can be studied by physical and chemical methods; a second group discuss effects of interactions between microbes; further papers describe the methods of survival of fungus and protozoa in nature and the effects of higher organisms on microbial survival and distribution.

Degenerative Changes in the Sternoclavicular and Acromioclavicular Joints in Various Decades, by Anthony F. DePalma, M. D. ($5.50, *C. C. Thomas Publisher, Springfield, Ill.)* It gives a comprehensive picture of the degenerations which occur in these joints at various age levels. It clarifies the complex anatomy of the shoulder joint and permits the clinician to place the correct evaluation on the abnormalities noted.

Clinical Orthopaedics, edited by Anthony F. DePalma, M. D. ($7.50, No. 9, 1957, *J. B. Lippincott Company, Philadelphia 5, Pa.)* This publication has been renewed each year. It is designed for original articles offering significant contributions to the advancement of surgical knowledge. It consists of original monographs on subjects of outstanding orthopedic current interest.

The Surgical Management of Pulmonary Tuberculosis, edited by John D. Steele, M. D. ($9.50, *C. C. Thomas Publisher, Springfield, Ill.)* Introduction by Frederick A. Coller, M. D., a Biographical Sketch of John Alexander, by Cameron Haeght, with a series of notable contributors. This book has been written for both interns and surgeons by thoracic surgeons who were trained by the late John Alexander and by two of his close medical associates. It covers all phases of procedure currently used.

Diagnosis and Treatment of Pulmonary Tuberculosis, by Paul Dufault, M. D. ($9.00, Second edition, *Lea & Febiger, Philadelphia 6, Pa.)* This is a current book dealing with the newer things in chemical and antibiotic therapy and lung function.

Dental Health Education, by Frances A. Stoll. ($4.50, *Lea & Febiger, Philadelphia 6, Pa.)* This is the first full-length text on this subject. It correlates the important approaches to dental health education: presentation of accepted concepts, the philosophy and teaching method, application of research and dental science to dental health instruction and a sociological approach to the home, the school, the community, in solving dental problems. Dr. Stoll presents dental health as an integral part

- postoperatively
- in pregnancy when vomiting is persistent
- following neurosurgical diagnostic procedures
- in infections, intra-abdominal disease, and carcinomatosis
- after nitrogen mustard therapy

for nausea and vomiting

VESPRIN

Squibb Triflupromazine

- provides prompt, potent, and long-lasting control
- capable of depressing the gag reflex
- effective in cases refractory to other potent antiemetic agents
- may be given intravenously, intramuscularly and orally
- no pain or irritation on injection

ANTIEMETIC DOSAGE:
Intravenous: 8 mg. average single dose
Dosage range 2-10 mg.
Intramuscular: 15 mg. average single dose
Dosage range 5-15 mg.
If subsequent parenteral dose is needed, one-half the original dose will usually suffice
Oral: 10-20 mg. initially; then 10 mg. t.i.d.

SUPPLY:
Parenteral solution – 1 cc. ampuls (20mg./cc.)
Oral tablets – 10 mg., 25 mg., 50 mg., in bottles of 50 and 500

SQUIBB *Squibb Quality – The Priceless Ingredient*

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of community life and provides at the same time authentic information and sources for teaching and instructional material.

Oral Hygiene, by Russell W. Bunting, D. D. S. ($7.00, Third edition, *Lea & Febiger, Philadelphia 6, Pa.)* Preventive dentistry is the theme throughout this widely accepted text. It is a large edition and contains new chapters on the pathology of dental caries. Also new chapters on the role of dental hygienists and the other chapters have all been revised and rectified to bring them up to date.

Clinical Parasitology, by Ernest C. Faust, Ph. D., and Paul F. Russell, M. D. ($15.00, Sixth edition, *Lea & Febiger, Philadelphia 6, Pa.)* Changing populations, especially migration from endemic areas, and greatly increased world travel, have contributed much toward the rising awareness of parasites and tropical diseases in the United States. Northern and eastern areas are not exempt from this potential infiltration. Encouragement lies in the significant modern concept which has been introduced in this edition of Craig and Faust's "Clinical Parasitology." It provides practical suggestions and recommendations for prevention of parasitic diseases in individuals, as well as in population groups.

An Introduction To Medical Science; An Elementary Text on Pathology, by William Boyd. ($4.50, Fourth edition, *Lea & Febiger, Philadelphia 6, Pa.)* Beginners in medicine will find this book to be of great value in explaining the nature and cause of disease and the accompanying bodily changes. The author is well-known to us all for his skill in writing.

Medical Research: A Midcentury Survey, Vols. I and II, published for The American Foundation. ($15.00, *Little, Brown & Company, Boston, Mass.)* Volume I deals with principle and practice. Volume II treats of the unsolved problems in biological perspective. The importance of basic research is emphasized throughout. Since all disease represents alterations in protoplasm, research in fundamental cytology is the need.

Medicine and Man, by Ritchie Calder. (50 cents, A Mentor Book published by *The New American Library of World Literature, Inc., 501 Madison Avenue, New York 22, N. Y.)* The story of the art and science of healing.

Recent Advances in Anaesthesia and Analgesia Including Oxygen Therapy, by C. Langton Hewer and J. Alfred Lee. ($8.50, Eighth edition, *Little, Brown and Company, Boston, Mass.)* A practical summary giving the pith of anesthesia practice.

Doctor and Patient in Soviet Russia, by Mark G. Field, with foreword by Paul Dudley White, M. D. ($5.00, *Harvard University Press, Cambridge 38, Mass.)* The book is a study in the sociology of the medical profession. It is not a study of Soviet medicine; nor is it an attempt to assess its techniques.

Pharmacology and Therapeutics, by Arthur Grollman, M. D. ($12.50, Third edition, *Lea & Febiger, Philadelphia 6, Pa.)* The outstanding text has been brought up-to-date with 12 new chapters on the new drugs.

Pharmaceutical Calculations, by Willis T. Bradley, C. B. Gustafson and M. J. Stoklosa. ($4.50, Third edition, *Lea & Febiger, Philadelphia 6, Pa.)* There have been no radical changes in this well-known text.

A Manual on Cardiac Resuscitation, by Robert M. Hosler, M. D. ($5.50, Second edition, *Charles C. Thomas Publisher, Springfield, Ill.)* The author, a Cleveland physician, now gives us a manual on a lifesaving procedure where scope is enlarging.

The Modern Drug Encyclopedia and Therapeutic Index, edited by Edwin P. Jordan, M. D. ($17.50, Seventh edition, *Drug Publications, Inc., 11 E. 36th Street, New York 16, N. Y.)* This work with its supplementary service is well known and appreciated by 125,000 physicians and pharmacists, as a handy desk volume of references.

Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death—Volume 2, Alphabetical Index. *(World Health Organization, Geneva, Switzerland.)*

Elements of Mathematical Biology, by Alfred J. Lotka, D. Sc. ($2.45, *Dover Publications, Inc., New York 10, N. Y.)* Formerly published as **Elements of Physical Biology** has been this first book which tries to apply modern mathematics to each of the biological sciences.

Report of the Committee to Review the Medical Care Program, Publication No. 77, by the Maryland State Committee on Medical Care. (50 cents, *Maryland State Planning Commission, 100 Equitable Bldg., Baltimore 2, Md.)* A review of this program to reduce care for the indigent and medically indigent in Maryland.

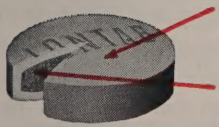
Blood Group Serology, by Kathleen E. Boorman and Barbara E. Dodd. ($7.50, *Little, Brown and Company, Boston 6, Mass.)* All aspects of the subject are treated in such a way as to give a good general picture, but concentrating on those which relate to the working of a serological laboratory.

X-RAYS SHOW HOW ONE PYRIBENZAMINE® LONTAB®

relieves allergy all day or all night

The unretouched X-ray films show how Lontabs release medication in the digestive tract. So that the prolonged erosion of the Lontab core could be visualized by X-ray, subject was given 10 Lontabs, each containing 100 mg. of a radiopaque substance in place of Pyribenzamine.

With its unique formulation, the Pyribenzamine Lontab not only relieves allergy symptoms promptly, but sustains relief as long as 12 hours.



Special outer shell releases 33 mg. Pyribenzamine hydrochloride within 10 minutes.

Unique core releases approximately 18 mg. Pyribenzamine hydrochloride the 1st hour, approximately 50 mg. from the 2nd to the 12th hour.

SUPPLIED: Pyribenzamine *Lontabs* — full-strength — 100 mg. (light blue).

NOW AVAILABLE: Pyribenzamine *Lontabs* — half-strength — 50 mg. (light green) — for children over 5 and for adults who require less antiallergic medication.

PYRIBENZAMINE® hydrochloride (tripelennamine hydrochloride CIBA)
LONTABS® (long-acting tablets CIBA)

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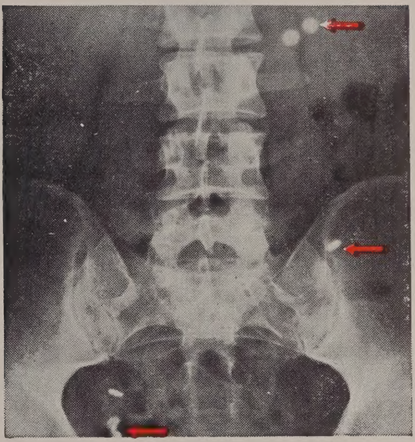
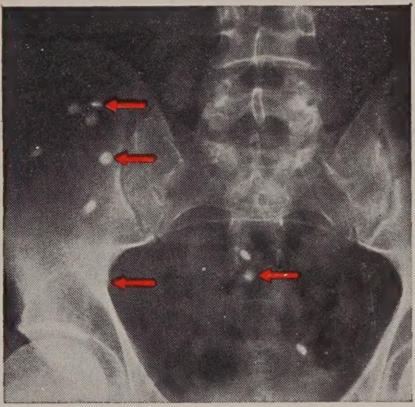
C I B A SUMMIT, N. J.

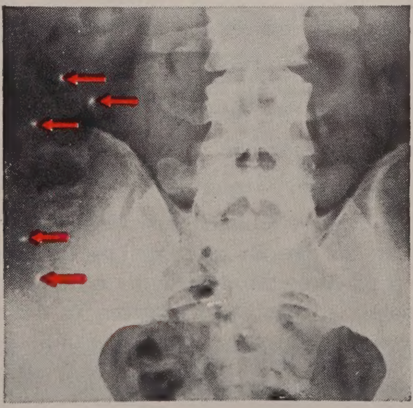
2 hours Lontabs are in the stomach and small bowel. Release of core substance is well under way.



4 hours Lontabs are in the ileum and cecum as core has steadily eroded.



8 hours Lontabs are still visible as substance of core continues to be released.



You and Your AMA

Some Highlights and Sidelights on the American Medical Association's Activities and Program

Nutrition Meeting

More than 500 physicians, nurses and dietitians will gather October 16 in Madison, Wis., for the fifth annual symposium sponsored by the AMA's Council on Foods and Nutrition. "Factors Involved in Formation and Disease of Bone" will be the subject under discussion at the one-day meeting to be held at the University of Wisconsin. Co-sponsors of the meeting will be the Medical School of the University of Wisconsin, the Dane County (Wisconsin) Medical Society, and the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin.

A highlight of the program will be a presentation by Willard Libby, Ph. D., of the Atomic Energy Commission, on atomic fall-out and radioactive stronium utilization in the human bone.

Series Plugs Health Care

Health tips for youngsters from "Dr. Dolliwell" is the theme of a new series of six transcribed five-minute spot announcements prepared by the American Medical Association. These radio platters feature a little girl who brings her doll to the family doctor for advice on various health topics, including safety, vaccinations, good nutrition and cleanliness. Medical societies wishing to book the series on local radio stations may contact the AMA's Bureau of Health Education.

Nomenclature Institute

The third in the 1958 series of regional Nomenclature Institutes will be conducted by the American Medical Association November 3-5 at the Benjamin Franklin Hotel in Philadelphia. This short course on the use of the *Standard Nomenclature of Diseases and Operations* is offered as a special service to medical record librarians and others working with the Nomenclature in the hospital, doctor's office or clinic.

Plans Group Practice Roster

The AMA's Council on Medical Service has been in the process of compiling information on group practices throughout the country and eventually plans to publish a directory of these groups. By early August the Council had information on 989 such groups located in the United States, Hawaii and Canada. Verification sheets have been sent out to those groups already on file. Physicians who practice in groups of two or more—who have not received a check sheet—are invited to send the following information to the Council: group practice name, address, office building (indicate whether rented or owned), number of physicians, and the specialties represented.

Named on Science Writers' Committee

John L. Bach, director of AMA press relations, has been named as one of five members of the 1958-59 planning committee for the National Association of Science Writers. Eugene Kone of the American Physical Society, New Haven, Conn., is chairman.

The committee agenda for the year includes preparation of a guide for the handling of press relations at all medical and scientific meetings. The committee also will consider extension of the seminar-type workshop sessions for science writers which were sponsored a few months ago by the American Medical Association in cooperation with the National Association of Science Writers. The first session was held in Syracuse, N. Y., and another in Cincinnati.

New Film on Food Quackery

How modern "medicine men" dupe the public into spending millions of dollars on unnecessary or over-priced nutritional products is the story unfolded in a new American Medical Association film.

Prepared especially for airing over local television stations under the auspices of local medical societies, the new 27-minute film—"The Medicine Man"—dramatically pinpoints the fight against quackery in the food and nutrition field.

The film singles out problems which stem from health lecturers who travel from town to town giving misinformation on nutrition as a tie-in to plugging their products of questionable merit and from door-to-door salesmen who misrepresent the value of nutritional products. The film also shows how the medical profession cooperates with the Food and Drug Administration and voluntary agencies such as the National Better Business Bureau in the crackdown on these food quacks.

Prints will be available to local medical societies after September 15 from the TV film library of the AMA.

New **Neo-Synephrine**®

Compound

Cold Tablets

for "Syndromatic" Control of
the Common Cold and Allergic Rhinitis

Neo-Synephrine now has three complementary compounds added to its own dependable, decongestive action for more complete control of the common cold syndrome.

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CAFFEINE 15 mg.

DOSE: ***Adults:*** 2 tablets three times daily.
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Bottles of 20 and 100 tablets.

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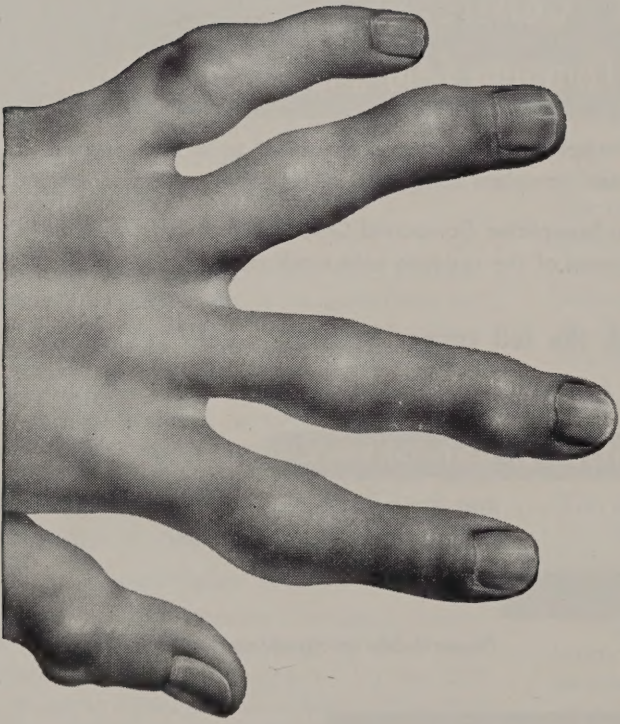
ARTHRITIS... OR GOUT?



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Clinical "curiosity" rather than clinical "instinct" is the key to accurate diagnosis of gout. Visible manifestations may not appear until late in the course of the disease. Moreover, the patient's description of the pain and the site of the pain may not differ markedly from other articular disorders.

THE FOLLOWING FINDINGS ARE HIGHLY INDICATIVE OF GOUT: (1) *Tophaceous deposits* resulting in irregular, asymmetrical deformity of joints; (2) *Elevated serum uric acid levels* (above 6 mg.%); (3) *Pain relief with colchicine.* When findings suggest gout, therapy with 'Benemid' should be started immediately.

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RECOMMENDED DOSAGE: 0.25 Gm. (½ tablet) twice daily for one week followed by 1 Gm. (2 tablets) daily in divided doses.

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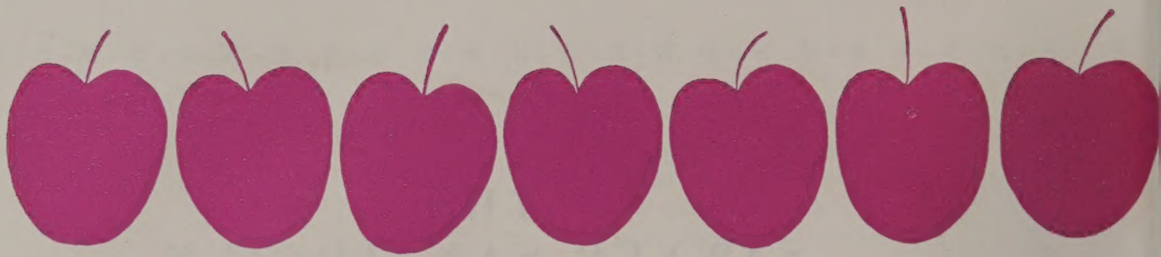

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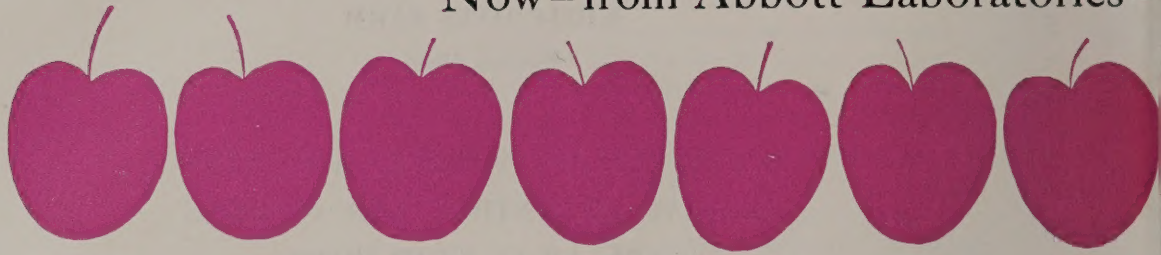

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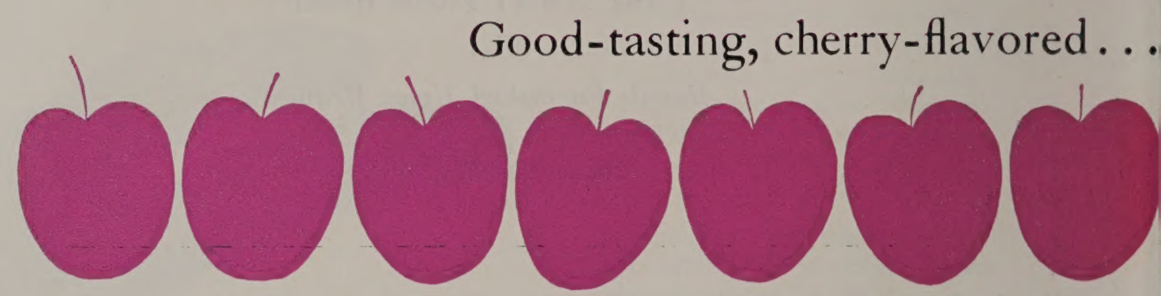

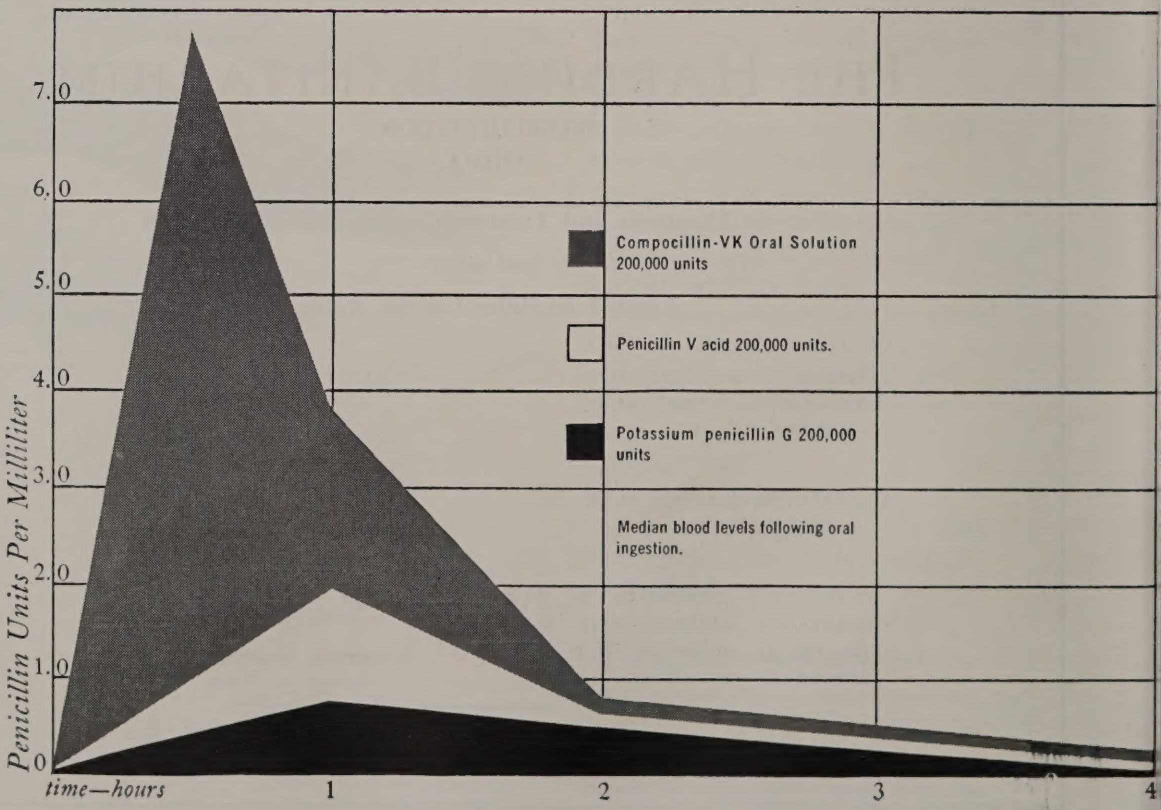
Penicillin Units Per Milliliter
7.0
6.0
5.0
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3.0
2.0
1.0
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time—hours
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3
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▨ Compocillin-VK Oral Solution 200,000 units
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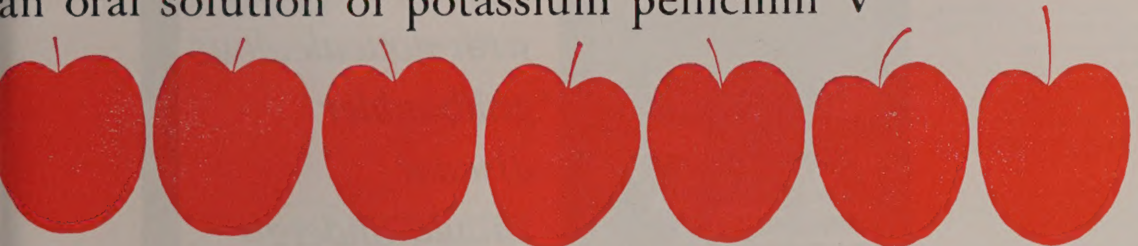
an oral solution of potassium penicillin V



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The clear, red solution has a fresh, cherry flavor, is taste-tested and is well-accepted by patients. And they'll get those high potassium penicillin V blood levels (note chart).

Compocillin-VK is indicated for all infections susceptible to oral penicillin therapy. Also, in treating recurring rheumatic fever and in managing rheumatic carditis. Compocillin-VK may be used in counteracting complications from severe viral attacks.

The initial recommended dose: In acute infections, the range is from 125 mg. (200,000 units) three times daily to 250 mg. (400,000 units) every four hours. For young children, the adult dose may be reduced in proportion to age and weight. For prophylactic use, 125 mg. (200,000 units) may be administered once or twice daily.

Compocillin-VK Granules for Oral Solution come in 40-cc. and 80-cc. bottles. Each 5-cc. teaspoon of the reconstituted solution represents 125 mg. (200,000 units) of potassium penicillin V. The dry granules stay stable under ordinary room temperatures. When reconstituted, the solution will remain potent for two weeks under refrigeration.

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which patients with noncalculous gallbladder disease should undergo surgery?

Essentially those who are not relieved by a prolonged trial period of medical management.
Source—Lichtenstein, M. E.: GP *16*:114 (Oct.) 1957.

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(brand of triacetyloleandomycin with gluCOSAmine)

Capsules / Oral Suspension

designed for effective control of common gram-positive infections

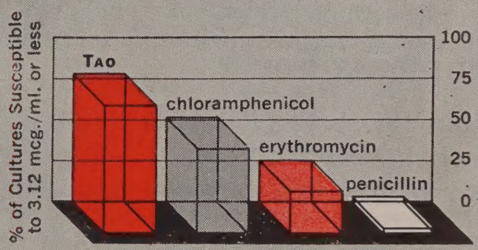
effective . . .

CLINICAL RESULTS	adults	children	all Staph infections
Cured	172 (80%)	148 (89%)	71 (88%)
Improved	28 (13%)	8 (5%)	7 (9%)
Failure	17 (7%)	11 (6%)	3 (3%)

Types of infecting organisms: The majority of identified etiologic microorganisms were Staph. aureus and Staph. albus. Tao has its greatest usefulness against organisms such as: staphylococci (including strains resistant to other antibiotics), streptococci (beta-hemolytic strains, alpha-hemolytic strains and enterococci), pneumococci, gonococci, Hemophilus influenzae.

even against resistant staph[1,2] . . .

Per cent of "antibiotic-resistant" epidemic staphylococci cultures susceptible to Tao, erythromycin, penicillin and chloramphenicol.[1]



well tolerated . . .

REACTIONS:

(a) adults	(b) children
Total—9.2% (20 out of 217)	Total—0.6% (1 out of 167)
Skin rash—1.4% (3 out of 217)	Skin rash—none
Gastrointestinal—7.8% (17 out of 217)	Gastrointestinal—0.6% (1 out of 167)

There was complete freedom from adverse reactions in 94.5% of all patients. Side effects in the other 5.5% were usually mild and seldom required discontinuance of therapy.

plus . . . stability in gastric acid • rapid, high and sustained blood levels • high urinary concentrations • outstanding palatability in a liquid preparation.

Dosage and Administration: Dosage varies according to the severity of the infection. For adults, the average dose is 250 mg. q.i.d.; to 500 mg. q.i.d. in more severe infections. For children 8 months to 8 years of age, a daily dose of approximately 30 mg./Kg. body weight in divided doses has been found effective. Since Tao is therapeutically stable in gastric acid, it may be administered at any time, without regard to meals.

Supplied: Tao Capsules—250 mg. and 125 mg.; bottles of 60. Tao for Oral Suspension—1.5 Gm.; 125 mg. per teaspoonful (5 cc.) when reconstituted; unusually palatable cherry flavor; 2 oz. bottle.

References: 1. English, A. R., and Fink, F. C.: Antibiotics & Chemother. (Aug.) 1958. 2. English, A. R., and McBride, T. J.: Antibiotics & Chemother. (Aug.) 1958. 3. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy (Aug.) 1958. 4. Celmer, W. D., et al.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 476.

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SCIENCE FOR THE WORLD'S WELL-BEING

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Social Security for Physicians . . .

Articles For and Against the Inclusion of Physicians Under the OASI Program Are Presented Before Poll Is Taken Among Members on Subject

AT the April meeting in Cincinnati, the House of Delegates of the Ohio State Medical Association adopted a resolution calling for a poll of OSMA Members on the question of whether or not physicians should be included under the Federal Social Security Program. This poll is scheduled to be held during the month of October.

The House of Delegates further directed *The Journal* to present in each of three issues (July, August and September) selected material and comments both for and against the inclusion of physicians in the OASI program. The first of this series of articles was presented in the July issue, beginning on page 868; the second in August, beginning on page 1010. This is the third in the series.

Members are advised that opinions expressed by the writers are those of the authors and do not necessarily reflect opinions of officials of the OSMA or staff members of *The Journal.*

* * *

Arguments For

By A. R. Felty, M. D.
Hartford, Conn.

Doctors Voting in Favor of Social Security 507
Doctors Voting Against Social Security 76

These were the final results of the Hartford County Medical Association referendum on Social Security conducted in September, 1956. Thus by a 7 to 1 vote, the physicians in one county of this State have unequivocally stated that they want Social Security. While these results may have jolted the faithful followers of organized medicine, they should in fact occasion no surprise, for when physicians take the time to learn the facts about Social Security, most of them will inevitably reach the same conclusions.

Well Established Law

Here are the facts about Social Security. It has been established as the law of the land for 21 years (since 1935). At the present time about 70 million workers are covered by Social Security, in fact, *virtually all* employed and self-employed workers (including lawyers and dentists). But not ALL—for employees of organizations proved to be subversive are excluded by law, and about 200,000 self-employed physicians are excluded because of the opposition of the AMA.

The spokesmen of organized medicine, notably the Board of Trustees and the Bureau of Medical Economic Research of the AMA, have steadily attacked, both in print and before the Ways and

(Continued on Page 1139)

Arguments Against

By Charles W. Pavey, M. D.
Columbus, Ohio

Last month in *The Ohio State Medical Journal* under the heading of "Arguments For Social Security" Dr. H. Fielding Wilkinson condescended to dissect some of the objections to Social Security in a grandiose manner that was obviously vastly satisfying to him, and I might add, to me. In attempting to destroy some of the more substantial arguments against the scheme he actually emphasized and confirmed them about as well as I have ever seen it done.

For example, he ridicules the idea that the Fund is bankrupt by saying that it has $23 billion in government bonds which include $3 billion in interest. Let us put this into simpler terms for easier understanding.

Example Cited

Suppose you had $8000 stashed away in a safe deposit box as a measure of security against illness, adversity or old age. A friend wants you to join him on an elephant hunt that will cost $8000. Your conscience hurts a bit about spending your security this way, so to salve your conscience you replace the money with a note signed by yourself not for $8000 but for $10,000 and bearing not 6 per cent interest but 10 per cent.

Hence, according to Dr. Wilkinson you can eat your cake and have it too. Not only do you have the fun of the elephant hunt but you made an immediate profit of $2000, and by waiting 10 years you can double your money. If you are fear-

(Continued on Page 1139)

Arguments For (Cont'd)

Means Committee of the House of Representatives of the United States, the basic principles and financial benefits of Social Security. They have advanced three main arguments.

(1) Argument—Social Security is represented as the entering wedge for socialized medicine.

Answer — *Social Security for physicians has nothing whatsoever to do with socialized medicine.* Tens of millions of American workers have been covered by Social Security for years without the advent of socialized medicine. The inclusion of 200,000 physicians in the program will not change the underlying structure of the Social Security Act. When and if socialized medicine ever comes about in this country, it will be due to other causes, not to the fact that doctors have Social Security.

Accepted as Insurance

(2) Argument—The law is actuarially unsound. Retirement benefits are described as too generous (*J.A.M.A.*, November 26, 1955, p. 1302). On the other hand, the price of survivors' insurance is declared exorbitant (*J.A.M.A.*, December 24, 1955, p. 1637). In an article in the *Journal A.M.A.* September 15-22, 1956, Drs. Webster and Coffey plunge boldly into a maze of actuarial intricacies to try to prove that Social Security is unsound, dishonest, and more expensive than regular insurance; and they even impugn the integrity of the duly elected members of Congress, and the honor of both political parties.

Answer—Actuarial soundness is a highly complicated matter which should be left to the actuarial experts. Our great life insurance companies accepted Social Security over twenty years ago. All their employees, including their presidents, their actuaries, and their medical directors are covered by Social Security. We do not hear them attacking the Social Security program.

However, since Drs. Webster and Coffey assailed the soundness of the program, their article has been analyzed by both government and life insurance actuaries, with this unanimous appraisal:—the premises on which Webster and Coffey base their arguments are fallacious, their reasoning is unsound, their conclusions are wholly erroneous and their prophecies are unjustified.

The charge made by Webster and Coffey that the cost of Social Security benefits exceeds that of ordinary insurance can be refuted by a study of the premium tables of any life insurance company. Furthermore, a careful cost study entitled "The Cost of Protection Comparable to Social Security" published in the *Bar Bulletin* of the Boston Bar

(Continued on Page 1142)

Arguments Against (Cont'd)

ful that you might not be able to repay the note at maturity you can make your wife sign it as a co-signer and you can also sign your own children's names since they are too young to sign for themselves. If at any time you should decide that the $10,000 plus interest might not be enough for your needs all you need do is increase the interest rate just like Congress votes the Social Security Fund bigger.

Shades of Ponzi!

Such is the wonderful world of H. Fielding Wilkinson and the other apologists for the Social Security Swindle. Shades of Ponzi and Alice in Wonderland!

The good doctor assures us that it is actuarially sound although he doesn't exactly offer any proof or supporting evidence for this statement beyond his own word that the size of the fund's current surplus fits the pattern anticipated 20 years ago.

Promises Made and Broken

If I may repeat a well known fact heretofore used in this discussion, 23 years ago the Social Security Act promised 33,000,000 people permanent insurance coverage after five years of payments but four years later Congress decided they should pay for 10 years instead of five.

The original act guaranteed the taxpayer that he or his estate would get his money back with interest if he did not use it up in annuities and this promise was kept to half a million beneficiaries and then arbitrarily cancelled to 33,000,000 others regardless of how they felt about it.

Political Expediences

Both the base taxable amount of pay and the rate have been altered more on caprice or political expediency than on the basis of the realities of the situation and Dr. Wilkinson would have us believe that the actuaries of 20 years ago accurately took all these things into account.

Status of Fund

On one point he is disarmingly frank and absolutely right and, it might appear, on our side of the argument. That is when he points out that any time the fund is in trouble Congress can rehabilitate it by increasing taxes. They might also solve the problem by repudiating the obligation as they did in '39.

Actually Dr. Wilkinson's statements in October of '57 were prematurely optimistic and a few months later in early 1958 it was acknowledged that the system was running in the red way ahead

(Continued on Page 1142)

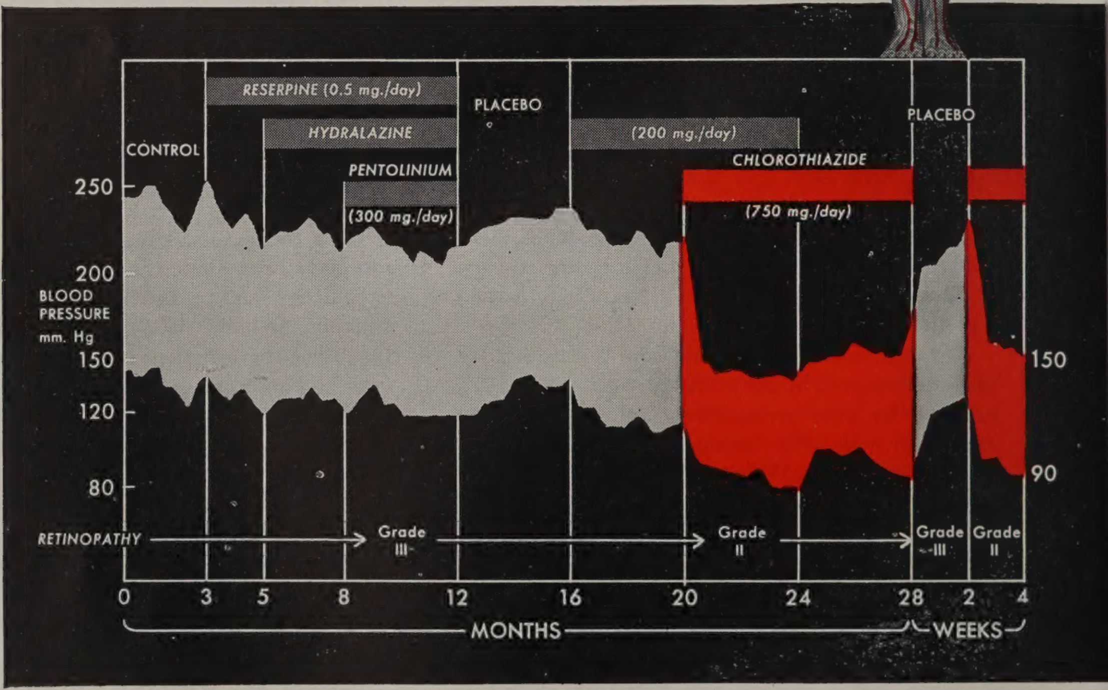
Investigator after investigator reports

Wilkins, R. W.: New England J. Med. **257**:1026, Nov. 21, 1957.

"Chlorothiazide added to other antihypertensive drugs reduced the blood pressure in 19 of 23 hypertensive patients." "All of 11 hypertension subjects in whom splanchnicectomy had been performed had a striking blood pressure response to oral administration of chlorothiazide." ". . . it is not hypotensive in normotensive patients with congestive heart failure, in whom it is markedly diuretic; it is hypotensive in both compensated and decompensated hypertensive patients (in the former without congestive heart failure, it is not markedly diuretic, whereas in the latter in congestive heart failure, it is markedly diuretic). . . ."

Freis, E. D., Wanko, A., Wilson, I. H. and Parrish, A. E.: J.A.M.A. **166**:137, Jan. 11, 1958.

"Chlorothiazide (maintenance dose, 0.5 Gm. twice daily) added to the regimen of 73 ambulatory hypertensive patients who were receiving other antihypertensive drugs as well caused an additional reduction [16%] of blood pressure." "The advantages of chlorothiazide were (1) significant antihypertensive effect in a high percentage of patients, particularly when combined with other agents, (2) absence of significant side effects or toxicity in the dosages used, (3) absence of tolerance (at least thus far), and (4) effectiveness with simple 'rule of thumb' oral dosage schedules."



In "Chlorothiazide: A New Type of Drug for the Treatment of Arterial Hypertension," Hollander, W. and Wilkins, R. W.: Boston Med. Quart. 8: 1, September, 1957.

MERCK SHARP & DOHME Division of MERCK & CO., INC., Philadelphia 1, Pa.

the effectiveness of 'DIURIL' (CHLOROTHIAZIDE) in Hypertension

as simple as 1-2-3

1 **INITIATE THERAPY WITH 'DIURIL'.** 'DIURIL' is given in a dosage range of from 250 mg. twice a day to 500 mg. three times a day.

2 **ADJUST DOSAGE OF OTHER AGENTS.** The dosage of other antihypertensive medication (reserpine, veratrum, hydralazine, etc.) is adjusted as indicated by patient response. If the patient is established on a ganglionic blocking agent (e.g., 'INVERSINE') this should be continued, but the total daily dose should be immediately reduced by as much as 25 to 50 per cent. This will reduce the serious side effects often observed with ganglionic blockade.

3 **ADJUST DOSAGE OF ALL MEDICATION.** The patient must be frequently observed and careful adjustment of all agents should be made to determine optimal maintenance dosage.

SUPPLIED: 250 mg. and 500 mg. scored tablets 'DIURIL' (chlorothiazide); bottles of 100 and 1,000.

'DIURIL' is a trade-mark of Merck & Co., Inc.

Smooth, more trouble-free management of hypertension with 'DIURIL'

Arguments For (Cont'd)

Association, December, 1955 shows that the cost of Social Security is only one fourth to one half as much as insurance premiums, to obtain comparable benefits.

Perhaps the best answer is that of a very prominent and distinguished insurance actuary when he was asked recently for his opinion of Social Security. His answer was terse and pointed: "Get all you can of it!"

(3) Argument—The physician is pictured as a man who never retires before he is worn out. "At least 85 per cent of physicians between 65 and 72 years of age in the United States are in active practice. . . . It would not be good public policy to unduly encourage them to retire." (F. G. Dickinson, Ph. D., director, Bureau of Medical Economic Research, AMA., *Bull. Essex County Med. Soc., N. J.*, March 1955, p. 167.)

Answer—It is a debatable point whether or not a doctor should continue to work until he is worn out. However, it is significant that the established practice of hospitals today is to *require* active staff members to retire from their posts at a definite age, usually between 62 and 65. Social Security does not require physicians to retire. It merely makes it easier for them to do so if they wish.

* * *

Profession Stands Alone

From the many millions of employed and self-employed Americans who are covered by Social Security, including doctors employed by industry, hospitals, and medical organizations, we hear nothing to justify the arguments which have been used to block admission of the medical profession into the Social Security program.

The Congress of the United States is ready to legislate when physicians say they are ready to join.

Spokesmen representing the AMA stated during congressional hearings on the 1956 bill that physicians are willing to accept voluntary, but are opposed to compulsory coverage. It has been pointed out repeatedly that the Social Security statutes do not provide for voluntary coverage. (The single exception to this concerns the clergy, because the Congress is unwilling to legislate in respect to religious bodies.) It is wholly unlikely that the Congress will ever yield to a single group, the AMA, when all other self-employed groups of workers have compulsory coverage. Both the American Bar Association and the American Dental Association, which previously held out for voluntary Social Security, have now accepted the principle of compulsory coverage, and are now in-

(Continued on Page 1144)

Arguments Against (Cont'd)

of schedule. The OASI actuaries seemed confused and uncertain. At first they said tax increases in 1960 would bring the system back in balance but this was soon changed to 1965. Congress obviously has misgivings on the subject and currently a study of Social Security financing is underway.

Redistribution of Wealth

As usual organized labor is using Social Security as a means for the redistribution of wealth along Marxist lines. They are constantly agitating for an increase in the base taxable amount of income in order to compel the higher income groups to finance their plan which is already subsidized by the employer who in turn passes the cost on to the consumer.

There is no reason to believe that this taxable base will stop short of $20,000 nor that the rate will stop even at 10 per cent. Then the $20,000 per man will pay four times as much as the $5000 man for the same protection. From this we can readily see that the real reason for the drive to include the medical profession is to compel a good risk, relatively high income group to subsidize their opposite numbers. No prudent man would voluntarily accept such an arrangement from a private insurer and it's hard to see how socializing a swindle makes it any less a swindle.

Tax Increased

Recently Congress debated the question of an "across the board" $20 deduction in income tax as a remedy for the threatened recession and then promptly turned around and raised almost everyone's taxes $26 dollars a year by increasing the Social Security taxable pay from $4200 to $4800 and demonstrated once more that benefits and premiums are not matters of contract, that they can and will be juggled for political expediency and that such a tax is subject to the basest kind of abuses.

Rightfully taxes are intended as a source of revenue for legitimate and fundamental government functions but the Social Security tax was conceived as, and the income tax has become, a means for Marxist redistribution of wealth. Make no mistake about this!

Marxist Principle

If you believe in the Marxist principle "from each according to his means, to each according to his need," if you believe in the progressive graduated income tax as a means for redistribution of wealth, then it is only logical that you should advocate inclusion of doctors in Social Security.

On the other hand, if you honestly believe in free

(Continued on Page 1144)

in angina . . .
less
pain—
less
tension

with new

CARTRAX*

PETN + ATARAX®

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why PETN? *For cardiac effect:* PETN is ". . . the most effective drug currently available for prolonged prophylactic treatment of angina pectoris."[1] Prevents about 80% of anginal attacks.

why ATARAX? *For ataractic effect:* One of the most effective—and probably the safest—of tranquilizers, ATARAX frees the angina patient of his constant tension and anxiety. Ideal for the on-the-job patient. And ATARAX has a unique advantage in cardiac therapy: it is anti-arrhythmic and non-hypotensive.

why combine the two? *For greater therapeutic success:* In clinical trials, CARTRAX was demonstrably superior to previous therapy, including PETN alone. Specifically, 87% of angina patients did better. They were shown to suffer fewer attacks . . . require less nitroglycerin . . . have increased tolerance to physical effort . . . and be freed of cardiac fixation.

1. Russek, H. I.: Postgrad. Med. *19*:562 (June) 1956.

Dosage and Supplied: Begin with 1 to 2 yellow CARTRAX "10" tablets (10 mg. PETN plus 10 mg. ATARAX) 3 to 4 times daily. When indicated this may be increased by switching to pink CARTRAX "20" tablets (20 mg. PETN plus 10 mg. ATARAX.) For convenience, write "CARTRAX 10" or "CARTRAX 20." In bottles of 100.

CARTRAX should be taken 30 to 60 minutes *before* meals, on a continuous dosage schedule. Use PETN preparations with caution in glaucoma.

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*Trademark

Arguments For (Cont'd)

cluded in Social Security under the provisions of the 1956 bill.

In spite of the fact that the spokesmen of the AMA have attacked Social Security on the ground that it is actuarially unsound, they have not opposed *voluntary* coverage for physicians. But, as a matter of fact, *voluntary* coverage *is* actuarially unsound because it violates one of the basic principles of group insurance, namely inclusive coverage of the entire group. Thus the stand of the AMA spokesmen is grossly inconsistent and contradictory.

All or Nothing Attitude

The physicians in the country may choose between compulsory coverage or nothing. A referendum which asks the doctor whether he wants voluntary Social Security is unrealistic—it asks whether or not he wants something that does not exist. A referendum which asks the doctor whether he wants *compulsory* coverage is prejudicial. It is asking a "loaded" question, in using the word "compulsory" which is intended to arouse an instinctive prejudice. The word "compulsory" is redundant. The only question confronting the physician is whether or not he wants to be included in this program of old age benefits and survivors insurance.

Some spokesmen of the AMA wish a tax-deferment retirement program (as provided in the Jenkins-Keogh bills) in place of Social Security. Neither the 83rd nor the 84th Congress showed the slightest inclination to take up these measures. It is unlikely that future Congresses will either, until physicians are included with all other groups of workers in the Social Security program. Furthermore, the Jenkins-Keogh bills are not a substitute for, but a supplement to, Social Security. Discussion of the Jenkins - Keogh bills is simply not relevant to the subject of Social Security.

Many physicians have heretofore been opposed to Social Security without studying the provisions of the act.

Some Facts and Figures

Social Security provides retirement income to those over 65, and a basic security income to widows, children under 18, and certain other survivors. In addition, the 1956 law provides for those over 50 years old who are totally disabled.

A self-employed worker, earning annually $4,200 or more, will now pay $141.75 per year. This figure will gradually increase every five years until 1975, when the cost will be approximately $265. Since most physicians earn $4,200 a year, they

(Continued on Page 1147)

Arguments Against (Cont'd)

enterprise, the market economy and the importance of initiative and opportunity and the virility of America, then you must logically be opposed.

Compulsion Hit

If you will agree that no one has a right to charge merchandise to your account without your knowledge or consent then you should be willing to forego the privilege of charging your Social Security benefits to someone else's account without their knowledge or consent, someone who may as yet not have been born.

Remember any kind of socialistic or cooperative scheme of this sort that anyone wants to try, on a voluntary basis, is their own affair but forced participation is an entirely different matter.

Some counries have turned to a National Lottery as a source of revenue but so far as is known participation is voluntary. The proponents of Social Security seemingly look upon it also as a lottery but want to make participation compulsory and universal. The arguments used are the same as the excuses of an inveterate numbers player and just about as valid.

Cost Is Not Low

Most advocates of compulsory inclusion harp on the low cost of Social Security but the cost is not low! Temporarily, the price may be, for the reason pointed out by the proponents, to wit: More contributors than beneficiaries.

This means that a large group is subsidizing a small group but when the so-called "low priced insurance" embraces the whole economy, when everybody is subsidizing everyone else then for all practical purposes no one is subsidizing anyone.

If I pay your insurance and you pay mine in the same amount there is no advantage to either of us and if this arrangement requires each of us to carry a type insurance not suited to our individual needs we are both losers.

Surplus Is Bookkeeping

Dr. Wilkinson points with pride to the $23-billion surplus which being in government bonds makes them a liability to the same government that regards them as an asset in one of its special funds. Hence, the $23 billion are not dollars at all but simply a bookkeeping entry but the potential claims against it are real. The 7,000,000 persons already receiving benefits will require more than $23 billion to satisfy their claims. There are almost one and one-half million others over 65 who have not as yet claimed their benefits but who are eligible.

(Continued on Page 1147)

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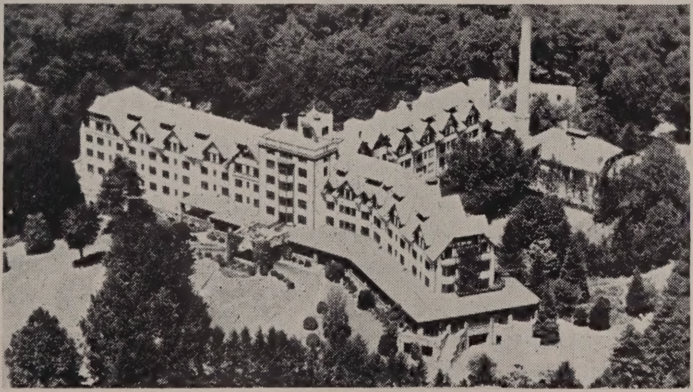

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references:
1 Grieble, H.G., and Jackson, G.G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958
2. Editorial: *New England J. Med.* 258:48-49, 1958.

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Arguments For (Cont'd)

would make these maximum payments and also receive these maximum benefits, as follows:

On retirement at 65, an individual physician would receive a monthly payment of $108.50 and when his wife becomes 65, they would together receive $162.80 a month—$1,953.60 a year. (At age 62 his wife may elect to receive 75 per cent of the amount which would be payable at age 65). If he chooses to work after 65—to quote the brochure of the Social Security Administration October, 1956, "No matter how much you earn in the year, benefit payments may be made for any month in which you neither worked for wages of more than $80 nor rendered substantial services in self-employment." Thus if he chooses to take a vacation for four months, he will receive payments during that period. Moreover, a self-employed physician over 65 would not be regarded as rendering "substantial services" if he devoted to his patients as many as forty to fifty hours a month; thus he might continue to earn several hundred dollars a month, and still be entitled to retirement benefits. At age 72 he receives each month his full retirement income, irrespective of his earnings. Income derived from sources other than "earnings" (e.g., interest, dividends, annuities, etc.) does not affect benefit payments.

At his death his widow, if over 62, receives $81.40 a month during her lifetime.

In case of his death at an earlier age, the law provides for his widow with two or more children $200 a month until the children become 18. Payments are resumed when the widow becomes 62.

At death of the insured person at any age, a lump-sum payment of $255 is paid to the surviving spouse.

Under the amended bill of 1956, the worker will receive monthly payments in the event of total disability after the age of 50.

For Young and Aged

In summary, the younger physician receives protection for his family in the event of his death. As he gets older he is protected in case of disability. At the retirement age of 65 he is privileged to receive a substantial monthly income as long as he lives, as does his widow who survives him.

Moreover, *every benefit payment under Social Security is exempt from all taxation.* In this unique respect it differs from almost every other form of income. In these days of high income taxes, this exemption provides very considerable savings.

The Board of Trustees of the AMA, in a statement regarding Social Security for physicians *(J.A.*

(Continued on Page 1148)

Arguments Against (Cont'd)

Their benefits, should they claim them, would require another $7 billion.

Potential Obligations

Next there are 25,000,000 who will become eligible at age 65. Their benefits will amount to $125 billion and finally there are 45,000,000 fully covered at present who may or may not be eligible at age 65. They represent a potential liability of from $267 to $500 billion depending on which government expert you choose to accept as an authority.

Despite Dr. Wilkinson's confidence this represents a substantial difference in actuarial estimates. This is not all. There is another lien. Survivor benefits represent a $350 billion liability covered by the same little $22 billion surplus.

Threat to Solvency

Government actuaries admit that this would be a catastrophic threat to solvency but for the fact that it is a compulsory governmental social insurance system that they assume will be perpetual in nature. What will happen should we be so unfortunate as to find ourselves in another depression with widespread unemployment deponent saith not. Neither can we predict the outcome should we have a sudden drop in birth rate, population and working force but the indications are that the political power of the older age group will insure them getting theirs.

Communist Manifesto

Right at a time when we are exhausting our resources for the "containment of Communism" abroad we seem intent on embracing the ten tenets of the Communist manifesto here at home.

Now we find even a segment of the medical profession intent on swelling the limitless bureaucracy of Socialism as though they didn't know or couldn't understand what they are doing.

But they should know. Everyone should know that the government can't reduce the cost of anything, not housing, power, insurance, transportation, medical care, hospitalization, nor anything else. What it costs it costs. If the government forces the price down below the actual cost—someone must make up the difference and that someone is you.

Anything we get without earning, someone else must earn without getting.

"Dream Castle"

The present Social Security Scheme is a dream castle built on a foundation of champagne bubbles.

(Continued on Page 1148)

Arguments For (Cont'd)

M.A., p. 1302, November 26, 1955), said, "Physicians as a group do not seek federal charity. . . . The argument that we should accept these windfall benefits because almost every eligible citizen will has little appeal to physicians. . . ." Others are more forthright and say they will not get aboard the "gravy train" with 70 million other Americans. Strangely enough, certain other opponents attack Social Security from the opposite direction. They contend it is a vast government swindle—"a Ponzi type shell game." How the American people can ride a "gravy train" and get swindled at the same time is not very clear.

Obviously the Social Security program, the fruition of 21 years of careful study, is neither a hand-out nor a hold-up. It is, in fact, one of the great social movements of this century. The citizens of the United States have underwritten the Social Security program as truly as they have underwritten the national defense program. You as a citizen have participated in underwriting it. Whether you will participate in its benefits is up to you.

In making your decision, do not let misleading words such as "socialized medicine," "compulsory," "welfare state" and other scarehead phrases confuse the issue.

The issue is simple.

Do you want this protection for yourself and your family?

Think it over and then VOTE.

* * *

By Frank P. Walsh, M. D.
Detroit, Mich.

Following is the text of an article "Why Not Participate in Social Security?" by Dr. Frank P. Walsh in the September 19, 1957 issue of the *Detroit Medical News:*

A Committee on Social Security for physicians has been formed. In a recently distributed pamphlet nine reasons are given to support the inclusion of physicians. A trustworthy expert in the insurance and investment fields was consulted. He agreed with the validity of the statements made and agreed conservatively they should be considered as sound in both categories.

The House of Delegates of the A. M. A. has repeatedly resolved that it is opposed to the compulsory inclusion of physicians as a group. I have talked to some of our local representatives in this assembly. They cannot state why this stand is taken except that it is a part of the profession's philosophy to oppose the intrusion of the Federal Government into the affairs of individuals. We

(Continued on Page 1150)

Arguments Against (Cont'd)

Everyone likes security, no one approves of poverty but it ill becomes a learned well-paid profession to clamor for a place at the public trough.

It seems that there is a well entrenched folk notion that physicians are incompetent in financial matters, an idea that is not altogether supported by facts. The very humanity of our profession may make us a bit remiss as bill collectors but indigent doctors are quite rare actually and with rare exceptions there would be little excuse for a willing, honest and industrious physician not being able to take care of himself and his family.

It hardly makes sense to burn down the barn of national solvency to get rid of the rat of old age dependency.

Wrong To Include All

An enforced savings plan for that segment of the population that cannot or will not make provision for its own old age may be justifiable even though it is subject to all of the abuses and objections previously listed but to include the remainder of the population, by compulsion, in the same scheme is indefensible and to establish dishonest rates for coverage in order to snare the unwary is downright immoral. (The people destined to pay for the shortest time will pay not only the least total amount, but also the lowest rate as the rate is scheduled to increase steadily as does the base taxable pay).

Time marches on. Change is inexorable. But there are also some eternal verities and we may be forgiven if our hearts respond to familiar sights and to some of the spiritual things that would need never change, the unyielding rock in a restless sea of turmoil and everlasting aimless probing that wears at the rock in its endless attempts at destruction.

Heritage of Medical Profession

Such has been the proud heritage of the medical profession and the men who made it. Benignly aloof, beloved and respected, not for their similarity to other men but because of their difference. Proud and independent, bold and self-sufficient they cheerfully accepted special responsibilities and received special privileges in return. They were a breed that walked humbly before God and proudly in society and then died serenely as only free men can.

Puts Questions To Physicians

What then has happened to those members of this proud profession who half-heartedly berate

(Continued on Page 1150)

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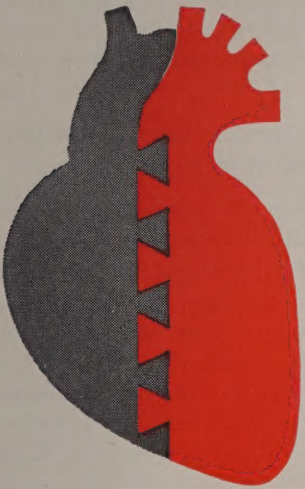

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[1] *Friedlander, H. S.: The role of ataraxics in cardiology. Am. J. Card.* 1*:395, March 1958.*
[2] *Shapiro, S.: Observations on the use of meprobamate in cardiovascular disorders. Angiology* 8*:504, Dec. 1957.*

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Arguments For (Cont'd)

are in agreement as to principle but not when present law excludes us from participation in a program we are helping to finance.

The director of the A. M. A. legal department, writing in the current issue of *Medical Economics,* considers the case against compulsory coverage by physicians. A prediction is made. 1. Congress will never authorize voluntary coverage. 2. Congress will force in the profession on a compulsory basis within five to ten years. 3. The medical profession should never ask for and never cease resisting compulsory coverage. The last statement I find difficult to reconcile with the first two.

A recent inquiry among friends and acquaintances in the profession informed me that of all who could voluntarily participate because of membership in another group, none had declined.

Facing Realism

With the philosophy behind resistance to compulsory inclusion, I am in agreement. However, we must be realists and consider our present economic environment. We may not like it but we are living in it. The trend has been established. We, as a small minority of the populace in general, do not agree with it. This is the stand that has been taken for us by our representatives in organized medicine. However, the majority of the people have decreed their pleasure. With the inevitability of inclusion becoming apparent, we would lose no more dignity than the American Bar Association has in declaring for inclusion. They polled their membership and declared the will of their majority. It is suggested our representatives follow their example. It is my belief that my fellow physicians if asked to express their opinion, would follow the pattern set by our legal friends. The foregoing generalization should be qualified to include men in medicine of forty-five years or less. The equivalent of about a hundred thousand dollars invested could barely begin to provide the amount of old age assistance benefits which are provided by the Act at age sixty-five for physicians in the age group included. Critically, I am skeptical of the soundness of the Social Security Plan when I visualize what it might cover when my children are my age. However, I would like the privilege of saving them from paying twice for my own old age assistance. I do not agree with the soundness of this trend away from the pioneer spirit of individual achievement, but I do feel that those who would like to participate should not be denied what is justly their right by the House of Delegates of the American Medical Association.

Arguments Against (Cont'd)

socialized medicine while demanding for themselves a governmental dole?

Have we become so absorbed in the pursuit of material wealth and so submerged in an avalanche of quasi science that we have abandoned all thought of understanding our environment? Are we no longer capable of recognizing socialism if it appears under another name or have we like the rest of the populace become ennervated to the point that we can embrace this foreign ideology for its lying unfullfilled promises?

If there is any truth in that old idea that the doctor was a notorious sucker for poor investments and fraudulent promotions let us hope that the current yearning by a minority of doctors for participation in the Social Security Scheme is a latter day version of the same naivete rather than a surrender of our real confidence and independence.

The medical profession will indeed have fallen upon evil days and socialized medicine, wearing seven league boots, will have come a step closer if doctors ever voluntarily surrender themselves to this degradation and madness.

God grant that something will appear to waken the medical profession from its dream world, jolt us back to reality and restore the "look of eagles."

Gastroenterological Convention Scheduled in New Orleans

The 23rd Annual Convention of the American College of Gastroenterology will be held at the Jung Hotel, New Orleans, on October 20, 21, 22.

In addition to the many individual papers to be presented, there will be panel discussions on gastric carcinoma, steroids in gastroenterology and functional disturbances of the gastrointestinal tract. There will again be scientific as well as commercial exhibits and the sessions will be open to all physicians without charge.

On October 23, 24 and 25, immediately following the Convention, Dr. Owen H. Wangensteen of Minneapolis, Minn., and Dr. I. Snapper of Brooklyn, N. Y., will again be the moderators of the Annual Course in Postgraduate Gastroenterology. The sessions will be held at the Jung Hotel and in the Auditorium of the Louisiana State University School of Medicine. Attendance at the Course will be limited to those who have registered in advance.

Copies of the program and further information concerning the Postgraduate Course and Mexico Regional Meeting may be obtained by writing to: American College of Gastroenterology, 33 West 60th St., New York 23, N. Y.

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You and Your Public . . .

Community Organizations Need and Welcome Assistance Medical Profession Has to Offer Them

MOST community organizations at one time or another find themselves contemplating or involved in projects that require medical advice.

What better source of advice can they find than that of the medical profession itself? The physician who takes an interest in these groups and makes available to them his knowledge and assistance is building strong public relations for himself and his profession.

This assistance should be given not just for the sake of public relations, but for the good of the medical profession. Last month this column called attention to three Ohio physicians honored for their long careers of community service, both as physicians and as citizens.

"Conditioned Reflex"

Such participation on the part of physician educates his fellow citizens to turn to the profession for medical advice in projects that involve questions of health.

This pertinent point is very capably developed in an address by Aubrey D. Gates, executive director, AMA Council on Rural Health. Addressing the 1957 annual meeting of the Colorado State Medical Society, Mr. Gates stated:

"Moreover, I subscribe to the slogan of the American Farm Bureau Federation that 'man's judgment is no better than his information.' There is yet much work to be done because education is a slow process."

By "education," Mr. Gates was referring to the task of intelligently presenting to the American people, in this instance particularly rural people, medicine's attitude and role in community life.

Help Is Available

He continued, "Furthermore, many organizations can and are eager to help (in this education). There are vast resources available in allies such as the Farm Bureau, Grange, Agricultural Extension Service, farm magazines, radio stations and television stations. They are waiting and willing for physicians to give leadership to worthwhile projects."

In other words, the personal participation of the physician can trigger the start of worthwhile undertakings in his community, and can guide them along the right path.

Mr. Gates made a most pertinent point here when he said, "I am not one of the people who believe that the physician in the community need necessarily be the Sunday School teacher, Boy Scout leader, or other things that lay people probably can do as well, but in health and medical care matters he is **the one** who can provide the necessary leadership and guidance in health and medical care."

Leadership Important

The importance of this leadership and guidance must not be minimized or shunted aside. Lay groups look to medicine for guidance in projects involving medical and health matters. There even may be instances where such projects involve these matters without the knowledge of the lay organizations.

If physicians fail to provide the advice and leadership in these instances, then the groups are forced to look elsewhere for such assistance. The result can be damaging to the community and to the profession, should this alternate source lack the knowledge and ability to give such advice and assistance.

American College of Surgeons Schedules Clinical Congress in Chicago

The 44th annual Clinical Congress of the American College of Surgeons will be held in Chicago, October 6 - 10. Headquarters will be The Conrad Hilton.

Dr. Robert L. Schmitz, Chicago, assistant professor of surgery, Stritch School of Medicine of Loyola University, is Chairman of the Local Advisory Committee on Arrangements.

Major addresses will be made by Dr. Newell W. Philpott, Montreal, incoming President of the College; Dr. George J. Curry, Flint, Michigan, authority on care of the injured; and Dr. Gunnar Thorsen, Stockholm, Sweden, distinguished surgeon and writer in the field of essential body fluids.

On the final evening, October 10, more than 1,100 Initiates will be presented for Fellowship in the College, Honorary Fellowships conferred, and officers inaugurated.

Details may be obtained from the American College of Surgeons, 40 E. Erie Street, Chicago 11, Illinois.

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EFERENCES: 1. Carlozzi, M.: Ant. Med. & Clin. Therapy 5:146 (Feb.) 1958. 2. Welch, H.; Wright, W. W., and Staffa, A. W.: Ant. Med. & Clin. Therapy :52 (Jan.) 1958. 3. Walch, E.: Dent. Med. Wschr. (April) 1956. 4. Shalowitz, M.: Clin. Rev. 1:25 (April) 1958. 5. Nathan, L. A.: Arch. Pediat. 75:251 June) 1958. 6. Cornbleet, T.; Chesrow, E., and Barsky, S.: Ant. Med. & Clin. Therapy 5:328 (May) 1958. 7. Stone, M. L.; Sedlis, A., Bamford, J., and radley, W.: Ant. Med. & Clin. Therapy 5:322 (May) 1958. 8. Harris, H.: Clin. Rev. 1:15 (July) 1958.

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A-5365-7-8

Washington Roundup . . .

News from the Nation's Capital of Interest to Physicians; Developments in Medical and Health Fields

As result of atomic radiation leakage at the Oak Ridge, Tenn., nuclear energy plant June 16, Atomic Energy Commission has given University of Cincinnati College of Medicine a $5,600 two-year grant to compile the nation's first handbook for physicians who must treat victims of serious radiation or nuclear accidents. The college's department of radiology and radioisotope laboratory will compile the handbook.

* * *

Supreme Court has ruled that Federal Trade Commission has no jurisdiction over accident and health insurance advertising in states that have their own laws on the subject—even though such laws are not being enforced. Ruling was a blow to commission's campaign against improper advertising in those fields.

* * *

Food and Drug Administration is studying plan to print special distinctive envelopes for use by drug houses for distributing required special drug warnings to physicians. Idea is that physicians would soon distinguish the warnings from routine promotional literature—and read them.

* * *

New director of the Hill-Burton hospital construction program is Dr. Jack C. Haldeman, who helped organize the program more than 12 years ago. He succeeds Dr. Vane M. Hoge, who left the directorship to become executive director of the Chicago Hospital Planning Council.

* * *

Dr. Aims C. McGuiness, medical affairs assistant to Secretary of HEW and key figure in the Administration's program to encourage more voluntary health insurance coverage, has warned physicians against boosting fees just because their patients are covered by insurance. He pointed out that "the mere fact that an individual pays health insurance premiums does not mean that he should be expected to pay more for a given unit of medical care than someone who is not insured."

* * *

U. S. Public Health Service, Office of Education and the Children's Bureau have recommended that state and local governments substitute tuberculin skin tests for x-rays in initial screening for detecting tuberculosis among students and school employes, with x-ray as follow-up on those with positive skin tests.

* * *

Medical advisory committee has recommended to Department of HEW that nation should treble its medical research expenditures and double its physician output by 1970. Report called for 14 to 20 new medical schools and for U. S. to supply half of medical research funds—$500 million by 1970—with industry and philanthropy supplying another $500 billion. Committee believes applied safeguards could eliminate dangers of Federal control of research in such a program.

* * *

National Library of Medicine is going to get a new and permanent home. Climaxing a crusade of many years, supporters of this move have won from Congress a $7 million appropriation to construct and equip a building to house the library.

* * *

Latest report of National Institutes of Health on evidence linking cigarette smoking with cancer and cardiovascular diseases shows that of 7,382 deaths among government life insurance holders in a 30-month period, 6,203 were smokers and 1,179 were nonsmokers—a death rate 32 per cent higher for smokers, who also had a lung cancer rate 10 times higher than nonsmokers.

* * *

U. S. Narcotics Commissioner Harry J. Anslinger has voiced strong objection to a joint report of an AMA-ABA committee recommending legalized dispensing of narcotics to addicts for outpatient care, at the same time rejecting the idea of clinic therapy supported by the AMA-ABA group. Anslinger charged that "their conclusions preceded the formation of the committee."

* * *

Public Health Service reports that infectious hepatitis is running higher than expected, despite downward trend in past four years. Also, increases in 23 states range from "slight" to 300 per cent. Meningitis cases are up from 1957, diphtheria and polio are down, with a more than 50 per cent decrease in paralytic polio.

In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

OSMA GROUP LIFE PLAN GOOD FOR GROUPS AND PARTNERSHIPS

In our opinion each physician who is engaged in group or partnership practice should seriously consider enrolling in the new Ohio State Medical Association Group Life Insurance Plan, available to members under 75 years of age even though he may be carrying other life insurance. In fact, this is something which should be discussed by each group or partnership at once.

Why?

The answer is found in excerpts from an excellent booklet, "Prescription for Medical Partnerships." It was prepared by Dr. Charles Maertz, at the time he was medical director of The Union Central Life Insurance Company, Cincinnati, and copyrighted by that company. Incidentally the Union Central is underwriting the OSMA group life plan.

The booklet after pointing out that every member of a group or partnership should have a buy-or-sell agreement with his colleagues to bring about orderly settlement in case of death, adds these important, timely words of how to fulfill the terms of the agreement:

"Yet even the most carefully worded buy-and-sell agreement is hazardous unless there are funds with which the survivor can fulfill his obligations to the widow. A younger doctor who is compelled to pay an older partner's widow a stipulated income may be uncertain about his ability to meet these commitments if the older man dies in the near future—before the younger has developed his practice to a point where he can afford this outlay.

"**The only workable method is an agreement funded by life insurance.** It is written on the life of each partner—with the premiums paid by, and proceeds assigned to, the other. **Only in this manner may a doctor-partner be certain of his family's security if he dies.** In that event, a surviving partner can become the owner of his own policy by reimbursing the deceased's estate for past premiums paid."

Queries regarding the OSMA plan may be addressed to the Columbus Office.

TWO BILLS AND THEY'RE NOT THE SAME

The magazine *GP* says it is constantly dismayed by the realization that the average person fails to distinguish between "hospital" bills and "doctor" bills and that too many times "he rolls them up in one fat lump and loudly proclaims that 'doctors charge too much.' "

How can you meet this situation?

GP offers this solution which is well worth a try:

That physicians spend more time drawing an important line. In fee discussions they should point out that there will be a charge for "physician services" and a charge for "hospital services"—and that the two aren't the same.

"Add if you care to," *GP* says, "that since 1936 family doctor fees have climbed 73 per cent; hospital room rates 265 per cent. We hate to see people misguided and confused."

HEALTH AGENCY SURVEY SUGGESTS ADVISORY COMMITTEES

A survey of the programs and activities of 38 volunteer health agencies conducted by the Columbus Academy of Medicine produced one recommendation in particular that warrants state-wide approval.

The survey report recommended that the Academy forward to each agency a list of physicians particularly interested in the disease to which the agency devotes its efforts. This list would be supplemented by advice that the physicians were available to serve on the agency's medical advisory board.

This list of interested physicians would make available to the agencies the advice and assistance of the medical profession. Who else would be more able to evaluate the work of these agencies in their efforts to combat disease?

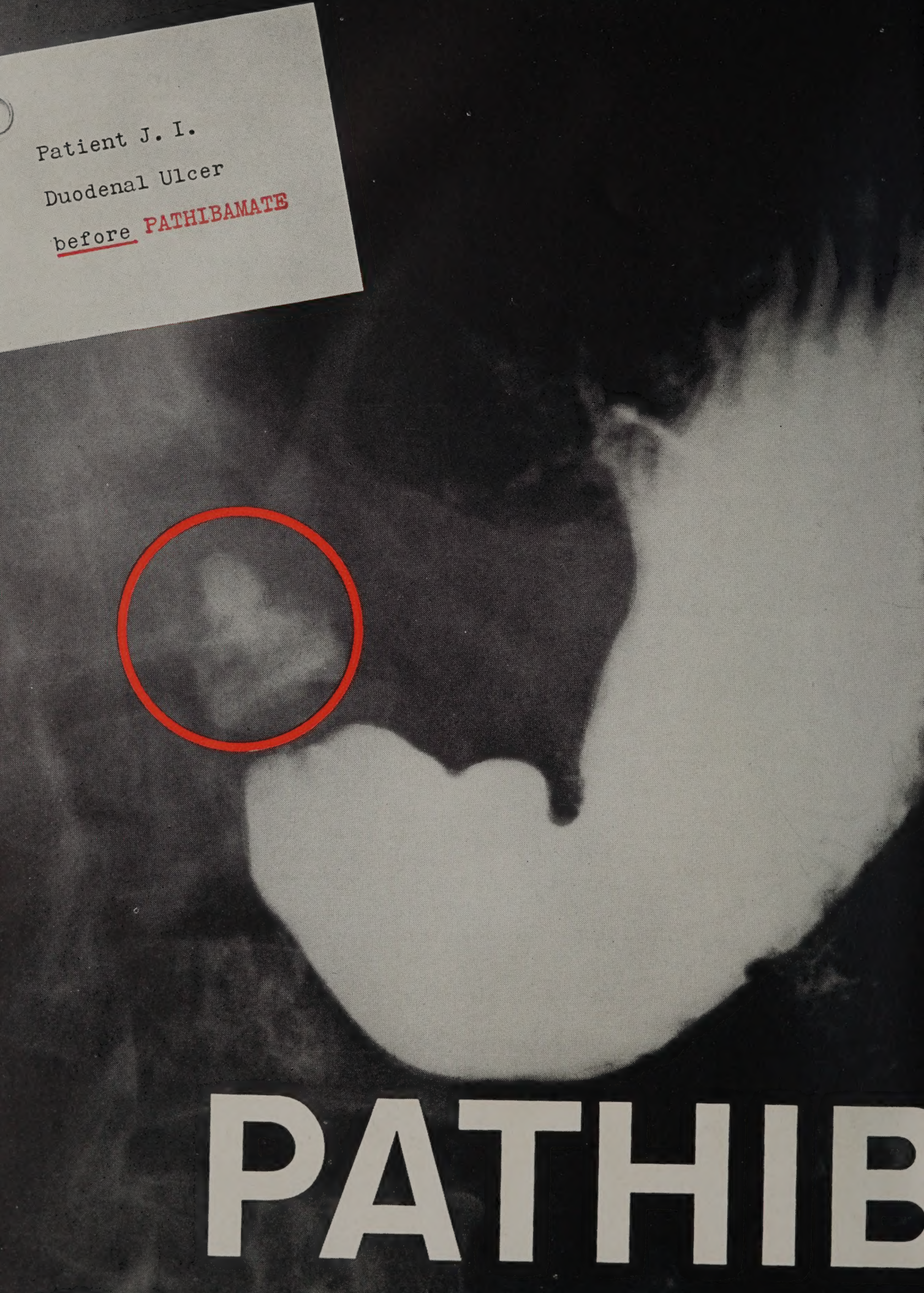
The medical advisory committee is invaluable; even indispensable. Other medical societies in Ohio that have not taken similar steps in their own localities might find it to their own interest to do so.

HERE'S WHY TAX MAN MAY BE CHECKING YOU

Here's some good advice for all physicians from the *ACADOgram* of the Cincinnati Academy of Medicine. Read it and—don't weep—but comply with the suggestions offered:

"Thousands of doctors are receiving notices for income tax audits. Reasons for questioning returns: 1. You've filed for a large refund. 2. You've failed to back up entertainment and travel deduc-

(Continued on Page 1158)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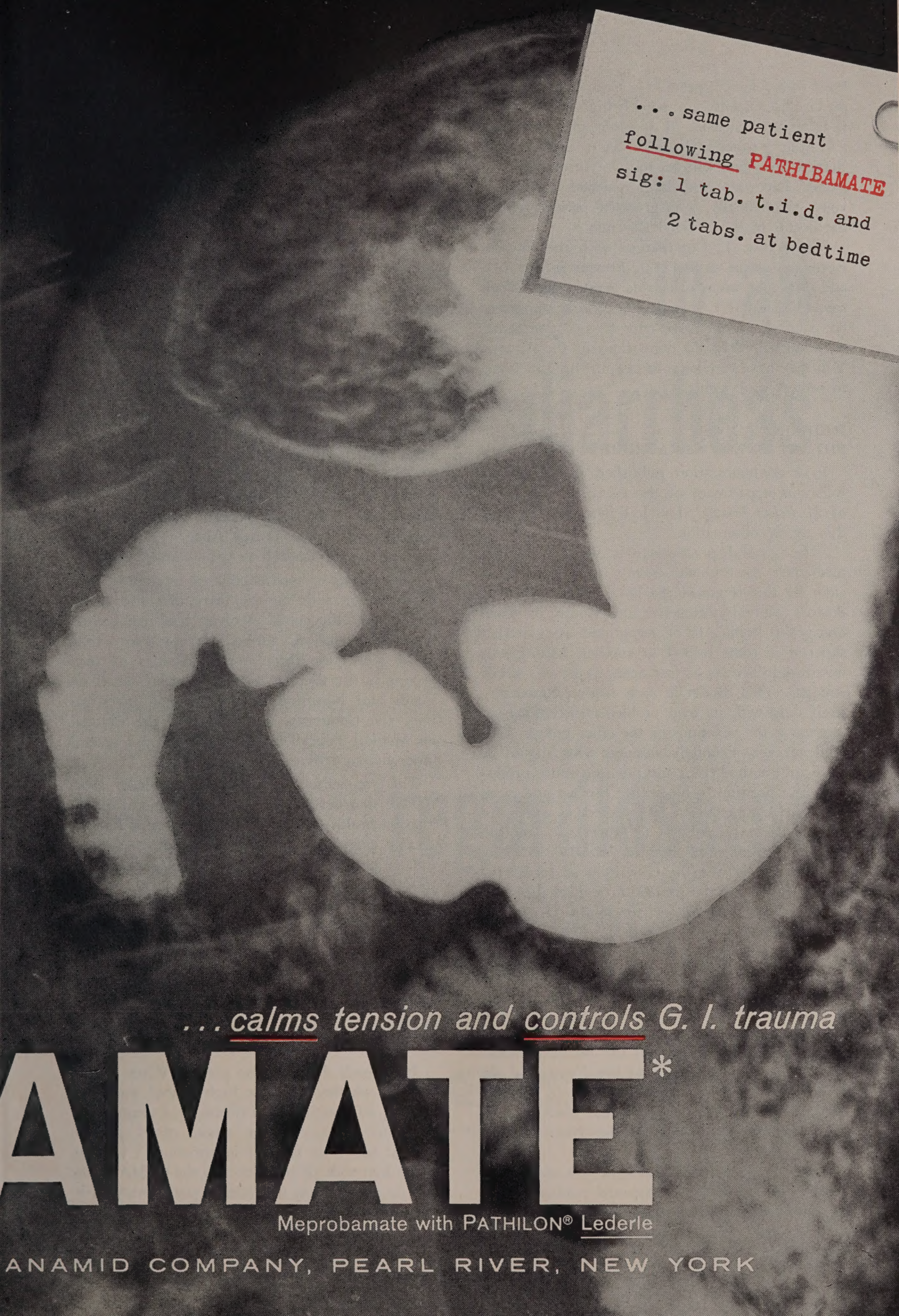

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tions with sufficient proof. 3. Your deductions for car or office expenses are notably high in relation to your reported income. 4. If you're in partnership, and your partner's return is being audited—the chances are yours will be, too. 5. Insurance companies have reported large payments made to you. Occasionally, a disgruntled patient reports the doctor to the Internal Revenue.

"Some tips: 1. Don't argue with the Internal Revenue Service auditor. 2. Present information and facts only when an item is questioned. When something doesn't seem right, consult competent tax counsel. Internal Revenue Service representatives are bound by the regulations of the Agency. You may have to take your case to the Tax Court to protect your rights."

MEDICINE'S MOST POTENT ENEMY—FRATRICIDE

In a communication published in the Public Relations department of the *Cincinnati Academy of Medicine Journal,* Dr. J. Edwin Reed offered this timely observation:

"The general practitioner is well aware that medicine's most potent enemy is medical fratricide. By this is meant the too great tendency of doctors to divide themselves into groups, in which one group hoping to be recognized as somewhat superior in some respect to another, wittingly or unwittingly divides or fragments medicine's whole strength. This results in each faction concerning itself only with its own problems and taking no interest in the vexations of the other groups. This tendency very definitely weakens what should be medicine's united front and puts the entire profession in a position to be further divided and more easily made to acquiesce to those forces which for some expediency, political or otherwise, choose to render the profession impotent."

Truer words were never written or spoken!

It is high time the profession realizes that fratricide means suicide for the entire profession anyway you look at it.

EVERY DOCTOR SHOULD BE HIS OWN LOBBY

Jonathan Wirtschafter, a second year student at Harvard Medical School, has written an article, "The Genesis and Impact of the Medical Lobby: 1898-1906." It appeared in the *Journal of the History of Medicine and Allied Sciences,* January, 1958. Reference to the article was made recently in the editorial columns of the *New England Medical Journal.*

In that editorial this statement was made:

"It was only when professional public-relations experts were employed to conduct a massive and successful campaign to influence legislation that the lobbying activities of the Association became more than mildly suspect to a considerable proportion of the population."

Be that as it may, (as a matter of fact, the enemies of the AMA made far more out of the so-called AMA lobby than the public at large) the lesson for the medical profession could be:

There will be no need for the medical profession to hire professional lobbyists if each and every physician will take it upon himself to discuss legislative matters with his own legislators; there will be no need for the medical profession to hire professional public relations experts on a mass basis if each and every physician carries on the right kind of public relations out of his own office and within the confines of his own practice.

THE MEDICAL PROFESSION AND CONTACT WITH THE PUBLIC

The "Questions and Answers" department of the *Journal of the AMA* poses some interesting developments. One doctor asked: "What direct contact does the AMA have with John Q. Public?"

The answer is too lengthy to reproduce here. It starts out with the summary that the AMA contact with the public involves three major areas —health education, public relations and public health protection through the activities of such groups as the Council on Drugs, the Council on Foods and Nutrition, the Bureau of Investigation, the Committee on Pesticides, the Council on Medical Education and Hospitals and several other similar activities.

The preparation of radio and television short subjects and developments of aids for local broadcasts on health subjects; the publication of *Today's Health,* popular health magazine; aid in preparation of health articles for popular magazines; distribution of pamphlets and other health aids to such organizations as Parent-Teacher groups, Granges, etc., are only some of the means whereby the AMA is keeping the public informed on health and medical matters.

In our opinion this procedure is multiplied 48-fold by similar programs on the part of state medical associations; and multiplied again by the activities of county medical societies.

It all boils down to one point: When a local citizen—whether it be a high school youngster seeking information for a theme, or a county commissioner—asks, "Doctor, where can I get authentic health or medical information?" you can direct him with all confidence to the OSMA or the AMA; and in many instances to your county medical society officers or committees.

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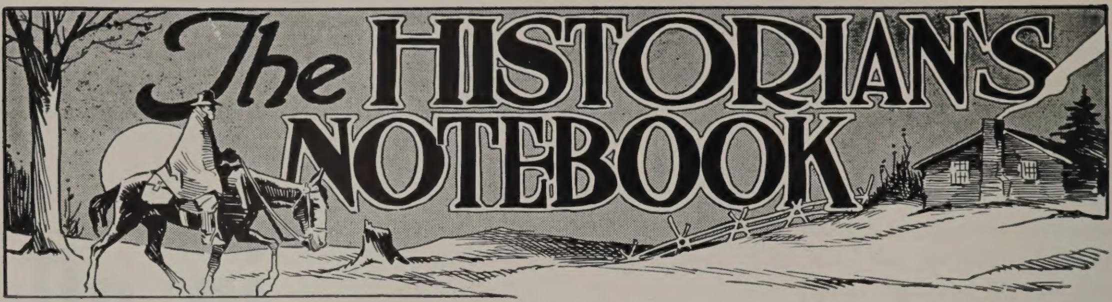

Dr. Mary Edwards Walker (1832 - 1919); Charlatan or Martyr?

LINDEN F. EDWARDS, Ph. D.

PART I

DURING the winter of 1864-65 the 52nd Ohio Volunteer Infantry Regiment was encamped near Chattanooga, Tennessee. On the morning of January 6, 1865, the assistant-surgeon attached to the Regiment was found dead in his tent. Imagine the shock experienced by the officers and troops of the Regiment when it was learned that the newly assigned assistant-surgeon was none other than a frail little woman physician wearing long curls but otherwise dressed like her brother officers in blue uniform, with gold stripes down the trouser legs, an officer's greatcoat and a wide-rimmed black felt hat with a gold cord.

This fragile woman, only a little over five feet in height, was Dr. Mary Edwards Walker, a modern counterpart of the Athenian woman physician, Agnodice, who almost paid with her life for impersonating a man in order to artfully disguise her sex. Unlike that hapless maiden, however, Dr. Walker was not attempting to masquerade as a man, otherwise she would have clipped her curls and assumed a masculine name. Her adoption of male attire was simply an expression of her life-long struggle for woman's rights and dress reform.

Dr. Walker was perhaps one of the most controversial characters in modern American history, being a living example of a person having attained fame on the one hand and of having been reviled and subjected to mockery and abuse on the other.

Her Many "Firsts"

Several "firsts" are credited to her. Thus, it is claimed she was the first woman physician to practice medicine in Columbus, Ohio; she had the distinction of being the first woman ever to have received a commission in the United States Army, of being the first woman physician ever to have served on a surgery staff in any army in time of war and the first woman ever to receive a Congressional Medal of Honor; she was a pioneer in the movement for woman's rights and suffrage and is said to have been the first American woman to attempt to cast a ballot in a legal election; it is claimed she was one of the first women newspaper reporters in the United States and one of the first women, if not the first, to study law in this country; she was among the first women to mount the lecture platform and address the public, at a time when it was thought that woman's place was in the home, and she has the distinction of being the only woman ever to have been expressly granted permission by Congress to wear male garb in public. In addition to this unusual record of achievement she is credited with having invented the inside neckband of men's shirts; originating the return postcard sent out with registered mail, and suggesting a method adopted by the Post Office Department for handling third class mail.

The Author

● **Dr. Edwards, Columbus, is Professor of Anatomy, The Ohio State University College of Medicine.**

Her High Price for Fame

Notwithstanding this enviable record, or perhaps because of it, Dr. Walker nevertheless paid

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A paper read at the meeting of the American Association for the History of Medicine, Williamsburg, Virginia, May 8, 1957.

a dear price for her fame and achievements. She was ridiculed by the press; she was the object of ribald humor by her fellow countrymen; members of her own sex made faces at her and even spat upon her on the streets; she was humorously dubbed a "self-made man"; she was arrested no less than a dozen times for masquerading in men's clothes; dogs were sicked upon her; boys rotten-egged her and once she narrowly escaped being tarred and feathered by a gang of young ruffians.

As may readily be expected there are several conflicting details concerning Dr. Walker's career. For instance, it is claimed that an unhappy marriage contracted early in her life was annulled, whereas, according to most of her biographers she was never married; she is said to have operated a tuberculosis sanitarium at her home in New York state; some say it was a nursing home, while others claim it was a training school for midwives; one of her bitter opponents maintained she had never been inside the walls of a medical college for the purpose of obtaining a medical education.

Her Independent, Self-willed Character

She was born on a farm located on Bunker Hill Road near Oswego, New York, on November 26, 1832. She was the daughter of Alvah and Vesta (Whitcomb) Walker, who had migrated westward from Greenwich, Massachusetts. She came from good sturdy New England stock, counting among her ancestors some of the early settlers of Plymouth Colony, including the noted Elder Brewster and the "Widow Walker." On her maternal side she was related to the Hoosier poet, James Whitcomb Riley, and to the religious iconoclast, Robert G. Ingersoll. Both of her parents taught in the local rural school which they had erected on their farm and which was the first free rural school in that section of the state.

Her father had been educated as a physician, a factor which undoubtedly influenced his strong-willed daughter to study medicine in spite of the popular prejudice against women invading the medical profession. At the age of 16 Mary was teaching school, alternating her terms of teaching with attendance at Falley Seminary in the neighboring town of Fulton, New York, where she first encountered masculine resentment by her male classmates for electing a course in human anatomy.

It was during her teaching career that she began to manifest an interest in woman's rights and particularly dress reform. She started to experiment with dress reform by wearing trousers which she partly concealed with short skirts and long coats. It is claimed that her objections to the style of women's clothing then prevalent, such as heavy skirts, artful pads like bustles and such torture instruments as corsets, were probably fostered by her father who considered these accouterments of feminine sham a menace to women's health.

At the age of 21 she entered Syracuse Medical College, which was an Eclectic institution that had been founded in 1849 and at its inception had adopted a policy of co-education, being the first medical school in the world to have adopted this policy. In February 1855 Dr. Walker was granted the M. D. degree and shortly thereafter began to practice medicine in Columbus, Ohio, where it is claimed she immediately met with marked success. One is inclined to doubt this claim because on November 16 of that year she married Dr. Albert E. Miller, one of her classmates in medical college, and they both settled in Rome, New York, to practice their profession.

As evidence of Dr. Walker's independent spirit were her insistence on being married in her reform dress; in spite of Dr. Miller's protest, of having the word *obey* stricken from the marriage ceremony and her refusal to forsake her maiden name, signing herself Dr. Mary E. Miller-Walker. It is not surprising, therefore, that a union between this self-willed woman and her rival physician-husband would not stand the test of time, even in those days when divorces were rarely sought for or granted, so that Dr. Miller soon deserted her. Being unable to obtain a divorce in New York state at that time on grounds of desertion she spent a year in residence in Iowa where she obtained her release from Dr. Miller in 1860. While there she enrolled in Bowen Collegiate Institute, from which she was suspended, so the story goes, because she succeeded in being elected to membership in a young men's literary society against the opposition of the administration and faculty. Having gained her freedom she returned to her home in Oswego, New York.

Her Contributions to the War Effort

Shortly after the beginning of hostilities between the North and South Dr. Walker volunteered her services. At first she aided Dr. Elizabeth Blackwell in organizing and training nurses for the Northern army and then transferred her activities to Washington, D. C., where she gratuitously gave her services toward the war efforts. For a time she served gratis as an assistant to the medical officer in charge of the Indiana Hospital located in the top floor of the Patent Office building and she spent considerable time visiting the hospitals in and about that city prescribing for the sick and performing operations just to be helpful. It is claimed that she even visited the battle fronts where she administered care to the wounded in the field and that she escorted the wounded from a camp hospital at the front to a hospital in Washington. Meanwhile, Dr. Walker had applied for a commission as assistant surgeon in the Northern Army and had obtained a diploma from the New York Hygeio-Therapeutic Medical College in New York City. She even sought employment as a spy and proposed to General Burnside a plan for entering the enemy's lines. Finally in October, 1864, she was commissioned a First Lieutenant and in January 1865 was assigned to the 52nd O. V. I. Regiment as Assistant Surgeon.

While serving in that capacity she began to administer medical care to the natives behind the lines, at first being accompanied by an escort of Northern soldiers but later travelled alone. She was strongly suspected of being a spy and while on one of these missions was taken captive by some Confederate soldiers and sent to Richmond, Virginia, where she spent four months as a prisoner in Castle Thunder. The story goes that during her imprisonment because of her craving for fresh vegetables she persuaded the commissary to include occasional rations of cabbage in the food given to the prisoners. She was finally exchanged for a Confederate officer of equal rank, a fact said to have been the only instance of its kind in history.

Following her release from prison she served for a time as a medical officer at a Female Prison in Louisville, Kentucky, and later was transferred to the staff of a Refugee Home at Clarksville, Tennessee. After her resignation from the Army in June, 1865, she worked for a short time as a reporter on a New York newspaper, meanwhile attending some lectures on law given by a Columbia University professor. Soon tiring of this pursuit she returned to Washington to practice medicine.

Her Lecture and Writing Career

On November 11, 1865, Dr. Walker was presented with an executive testimony in recognition of her war services signed by President Andrew Johnson and was awarded a Congressional Medal of Honor "for bravery and valuable services in the field." Unfortunately the officials neglected to record this event in the War Department Archives and on February 15, 1917, the Board of Medal Awards ordered the medal stricken from their list. Indicative of the bitter opposition of Dr. Walker's assumption of male attire during the war period in spite of her contributions is the absence of her name in an 800 page book entitled *Woman's Work in the Civil War: A Record of Heroism, Patriotism and Patience* published in 1867 and in which the statement appears, "Those who from whatever cause donned the male attire and concealed their sex are hardly entitled to a place in our record."

An illustration of the existing prejudice of male members of the medical profession at that time against their sister members is contained in a letter to the editor of the *New York Medical Journal,* May 1867, written by Dr. Roberts Bartholow of Cincinnati, Ohio, who had also served as an assistant surgeon in the Army of the Cumberland. He bitterly denounces Dr. Walker and claims that during her examination by the Medical Board assigned to examine her qualifications when she reported for duty at Chattanooga, Tennessee, she betrayed such utter ignorance of medical science that the board found it difficult to conduct an examination. It was he who charged that "She had never been, so far as we could learn, within the walls of a medical college or hospital for the purpose of obtaining a medical education."

(To be Concluded in October Issue)

Successful One-Stage Pneumonectomy For Carcinoma 25 Years Ago

We thought it would be of interest to review some of the major features in connection with carcinoma of the lung. It is always of tremendous interest that it was only 25 years ago that Dr. Evarts Graham of St. Louis, Professor of Surgery at Washington University, performed the first successful one-stage pneumonectomy for carcinoma. All of that is necessary, because it wasn't the first pneumonectomy, it wasn't the first for carcinoma, and it wasn't the first one-stage pneumonectomy. But it was the first successful one-stage pneumonectomy for carcinoma—25 years ago, an amazingly short length of time in the history of medicine. It is also a tragic paradox that Dr. Graham died just last year of carcinoma of the lung.—Edward F. Parker, M. D., Charleston, S. C.; *J. South Carolina M. A.,* 54:207, June, 1958.

Says Reader's Digest Wrong

Dr. A. S. McCormick, Akron, historian for the Summit County Medical Society, has advised *The Journal* that a recent article in *Reader's Digest* regarding the late Dr. Halsted, Baltimore, contained a factual error. It stated that Halsted was the designer and introducer of a chart to record temperature. Dr. McCormick states that this was an error. He says that in 1883 Dr. Ebner Edgar Foltz of Akron designed the "Thermograph," now known as the clinical chart and that he sold the patent for fifty cents, the buyer profiting to the extent of $50,000.

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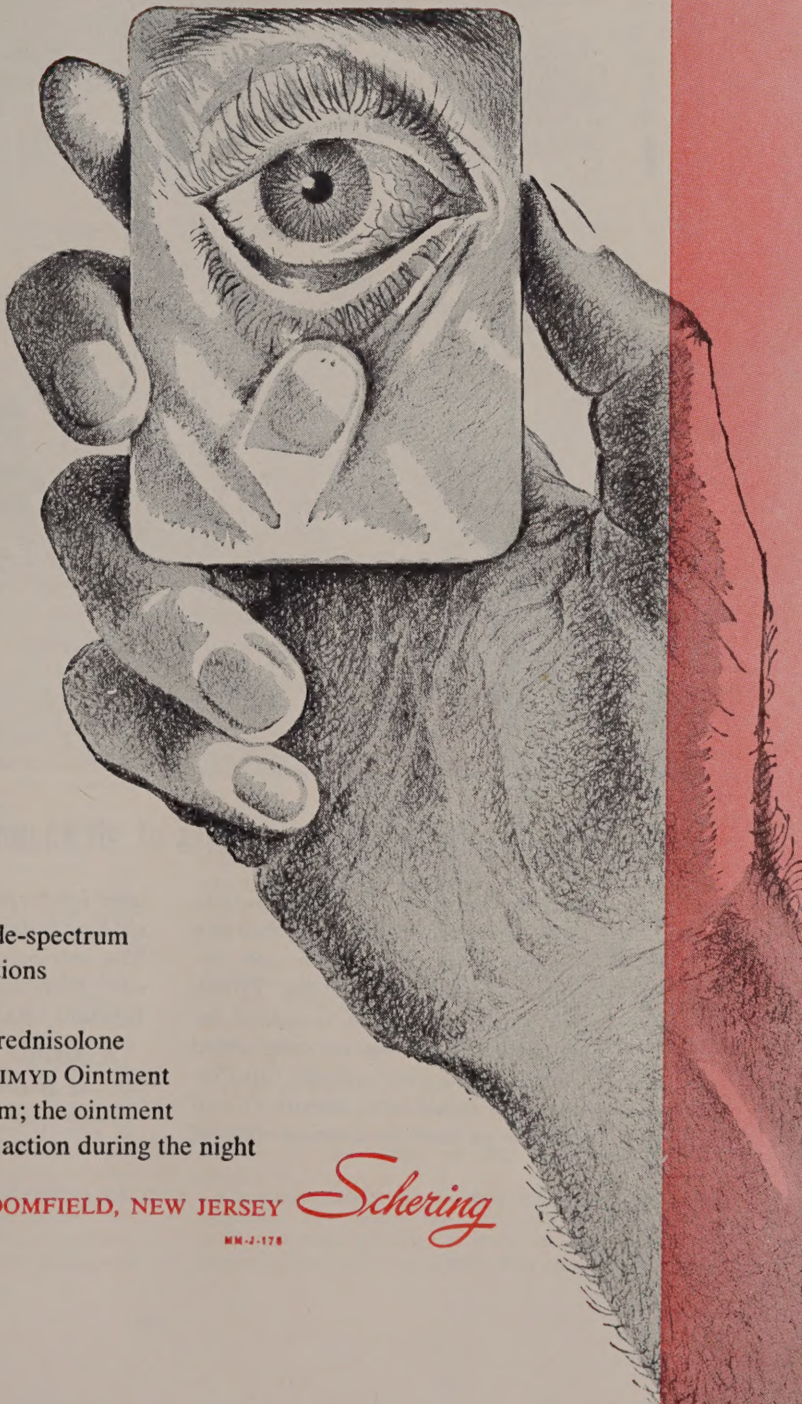

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JONATHAN FORMAN, M. D., *Editor*

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Alcohol Sensitivity in Hodgkin's Disease (Report of Two Cases)

DUANE N. TWEEDDALE, M. D., JOHN B. WHELAN, M. D., AND FRANCIS L. BROWNING, M. D.

The Authors

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- **Dr. Whelan, Cleveland, is a member of the staffs of Huron Road, St. Vincent's Charity, and St. Ann's Hospitals; courtesy staff, The Woman's Hospital.**
- **Dr. Browning, Shaker Heights, is a member of the surgical staff, The Woman's Hospital.**

IN 1950, Hoster[1] first recorded the occurrence of pain in patients with Hodgkin's disease following alcohol ingestion. Since his report, over 30 instances of sensitivity to alcohol in patients with Hodgkin's disease have been recorded. (See table 1.) Because such sensitivity may become manifest as the earliest symptom of Hodgkin's disease and may be useful in following the therapeutic course of the disease, the following case reports are presented.

Report of Cases

Case 1: A white female, age 50, first noticed enlarged right cervical nodes in September, 1954. These were painless, and seemed at times to disappear, only to recur.

In August, 1955, she had an acute flare-up of inflammatory rheumatism, which subsided under penicillin, Gantrisin® and cortisone. Following this, the enlarged glands on the right side of her neck became very small and barely palpable. She was seen again in February, 1956, with a right lobar pneumonia. At this time the glands on the right side of her neck were again enlarged. About two weeks after her recovery from pneumonia, during which penicillin and sulfadiazine were used, her cervical glands were observed to be small, non-tender, and just palpable.

In the ensuing four months, the cervical glands again became enlarged, and a biposy was done revealing a proliferative, inflammatory, glandular hyperplasia. She then began to lose weight, become short of breath on the least exertion, had dizzy spells, a very rapid pulse, and had no appetite or pep. At this time she noticed that whenever she imbibed alcohol there occurred pain in the back that radiated into the abdomen. It was so severe that she voluntarily discontinued all alcohol. The pain commenced about five or ten minutes after alcohol ingestion. It started as a dull ache in the lower part of her back, increased in intensity until it girdled her abdomen. This made her walk stooped over, and clutch her abdomen. This lasted about one to two hours and gradually diminished. About one week before she was admitted to the hospital, she experienced the same reaction after a second dram dose of Elixir Butisol® Sodium.

She was re-hospitalized in January, 1958. Her previous slides were reviewed and a diagnosis of Hodgkin's paragranuloma was rendered which was confirmed by Dr. J. R. McDonald of the Mayo Clinic, Rochester, Minnesota. She was then given a course of deep x-ray therapy to cervical and retroperitoneal glands following which all enlarged and palpable nodes practically disappeared. About 10 days after therapy, she was encouraged to try a martini, which she did, with none of the symptoms described above.

Case 2: A white female, age 27, consulted her physician because of difficulty in swallowing, pain under the left shoulder blade after the ingestion of alcohol, and enlargement of the neck. Her symptoms had been present for three months. She stated that severe, sharp pain beneath the scapula commenced about 10 minutes after alcohol ingestion and lasted for two to three hours. Except for bilateral, shotty, cervical lymphadenopathy, the physical examination was not remarkable. A biopsy of one of the nodes revealed a typical Hodgkin's granuloma.

Deep x-ray therapy was then instituted with a good response. Her nodes became much smaller and her symptoms were partially relieved so that after alcohol ingestion she had only a dull subscapular ache. At this point, the patient became pregnant and throughout the entire pregnancy there were no symptoms referable to her Hodgkin's disease. However, three months after the termination of pregnancy, she was readmitted to Woman's Hospital because of recurrent neck swelling, weakness, sweating, fever, and pain aggravated by alcohol ingestion. At this time, she was given x-ray therapy and nitrogen mustard. Response was only fair and a dull

TABLE 1. — *Alcohol Sensitivity in Hodgkin's Disease*

Author and Year	Age	Sex	Pain	Other Sym.	Loca. of pain	Rx Effect	Onset	Duration	Comment
Hoster[1], 1950	States has freq. observed pain in patients with alcohol inbibition. Suggests edema as cause. No report of a specific case or cases.								
Portman, U. V.[2], 1950	Noted sherry wine in gelatin dessert can cause severe pain. States reaction occurs immediately. Cough or itching may be produced. No report of case.								
Verbeeten 1952[3].	44	M	x	....	Shoulder and between clavicles.	....	....	....	....
	30	M	x	....	Sternum	Relief	15 min.	....	"horror alcoholis"
	65	F	....	itch over entire body, neck constriction	Neck	No relief	immed.	....	....
	27	M	x	....	Rt. side	....	immed.	....	....
Bichel and Bastrup-Madsen[4], 1953	29	M	x	Oppression in chest. Sense of suffocation	Retrosternal, down thigh	....	2-3 mins.	20 mins.	granuloma type.
	26	F	x	....	Ant. aspect thigh	....	immed.	15 mins.	granuloma type.
	26	M	x	....	Right side of chest	Relief	immed.	....	granuloma type.
	24	F	x	....	Burning retrosternal	....	few mins.	to ½ hr.	granuloma type.
	34	M	x	....	Lower thoracic	No relief	immed.	½ hour	granuloma type.
	28	M	x	....	Lumbar, sacral	....	....	....	granuloma type.
	52	F	x	....	Right arm	Relief	almost immed. to 5 mins.	1 hour	granuloma type.
	31	M	x	....	Across chest	....	immed.	10 mins.	granuloma type.
	20	M	x	....	Left side of chest	....	Shortly after	....	granuloma type.
De Winter[5], 1953.	37	WF	x	....	Coccyx	Relief	few mins.-6 mins.	1 hour	Painful areas localized the disease before it was detectable
	25	WF	x	....	Chest & Back	Relief	....	....	
Petch[6], 1953.	56	M	x	....	Hypogastric	....	....	....	....
Hall & Olson[7]	20	M	x	....	Bones	....	Few mins. IV alcohol	....	Dx previously established
		M	....	Increased in node size and fever	Peripheral nodes	....	....	....	....
Godden, Clagett, Andersen[8], 1956	37	FW	x	....	Chest & Shoul.	Relief	5 mins.	....	granuloma type.
	36	FW	x	....	Lt. neck, shoul. and upper extremity	Relief	Abrupt	10-15 mins.	granuloma type.
	35	MW	x	....	Low back & chest	Relief	2 mins.	15-20 mins.	
	25	MW	x	....	Lt. triceps	....	....	35 mins.	granuloma type.
Conn[9], 1956	—	F	x	....	Cervical, axillary, inguinal	Relief	immed.	....	Prompted Dr's dx of Hodgkin's disease
	15	—	x	....	Sternum	Relief	20 mins.	....	
			He notes two patients with Hodgkin's disease who had generalized aching, a slight feeling of ill health lasting 12-36 hours.						
Albahary[10], 1956	39	M	x	....	Supraclavicular	Relief	immed.	1 hour	
Tweeddale, Whalen, and Browning	50	WF	x	....	Back and abdomen	Relief	5 to 10 minutes	1-2 hours	Hodgkin's paragranuloma.
	27	WF	x	....	Subscapular	Partial relief and full relief	10 mins.	2-3 hours	Hodgkin's granuloma

Reports by Alcozer and Azzenda[11] (1955), Sandor[12] (1955), Schwarz[13] (1956), and Greiner [14] (1956) have also occurred. The articles were not available for review.

ache persisted following alcohol. However, four weeks after discharge, she was readmitted for more x-ray therapy with a more gratifying result and reported no pain after three beers.

Discussion

The commonest manifestation of alcohol-induced sensitivity in Hodgkin's disease is pain; however, generalized pruritus, cough[2], a sense of suffocation or oppression in the chest[4], increase in size of nodes and fever[7], and a generalized feeling of ill health[9] have also been noted. The pain commonly follows only minute amounts of alcohol. Indeed, Portmann[2] noted that the sherry wine in gelatin desserts can cause severe pain and our Case 1 had pain following two teaspoonfuls of Elixir Butisol Sodium. Pain usually appears immediately although a latent period up to 20 minutes may occur[4]. Duration has been noted to run from 10 minutes[4] up to one hour[4,5,10] but our patients had pain lasting for 2 and 3 hours respectively. However, the majority experience pain for 30 minutes which usually leaves spontaneously.

The pain is characteristically more severe than the spontaneous pain of Hodgkin's disease and indeed, Verbeeten[3] has referred to it as "horror alcoholis." It usually occurs in areas involved by the disease process. Thus, the upper half of the body is more often the seat of pain with the chest bearing the brunt of the attack[4,5,8,9]. However, cervical areas, shoulders, back, thigh, and rarely the hypogastrium[6] may be affected. Interestingly enough, the syndrome of pain with alcohol ingestion may antedate other symptoms of the illness[5,9]. Because of this factor, such a sequence of events should prompt careful investigation for underlying Hodgkin's disease. While such induced pain usually indicates Hodgkin's disease, there are rare instances when a patient with another disease as well as an unusual normal individual may demonstrate such a train of events[9].

The frequency of such a syndrome in a series of Hodgkin's disease cases has been reported from only a rare finding[8] up to 14 per cent of individuals[4]. Most patients were in the third and fourth decade of life with a sex ratio of approximately 1.3 males to 1 female. This is at variance with the usual distribution in Hodgkin's disease of 2 or 3 males to 1 female.[15]

The occurrence of this syndrome in a patient with Hodgkin's disease has up to now only been reported in those individuals with the granulomatous form.[4,8] Our Case 1 is unique in that it is of the paragranulomatous type of Hodgkin's disease.

Following therapy, most patients have been shown to lose their sensitivity to alcohol.[4,5,8,9,10] For this reason, in such a selected group alcohol sensitivity testing may be a valuable guide for initiating therapy, for reinstituting treatment and also may aid in locating zones for therapeutic attack. It might be added that the alcohol apparently does not affect the overall prognosis[5].

The cause for this curious phenomenon has not been satisfactorily answered. Whether edema due to altered vascular permeability,[1,2] histamine release,[4,8] or the release of a lymphogranuloma enzyme similar to Antabuse®[10] is primarily responsible is conjectural. It has been shown that the injection of histamine or other vasodilators such as intravenous nicotinic acid amide, or local application of glyceryltrinitrate ointment over involved areas does not reproduce the syndrome.[4] The only factor apparently capable of producing the syndrome is the presence of alcohol, either pure, or in combinations of innumerable palatable concoctions.

Summary

The authors have presented two cases of patients with Hodgkin's disease who demonstrated sensitivity to the ingestion of alcohol. The literature is briefly reviewed. The importance of further investigation of a patient who develops pain following alcohol consumption is stressed. The syndrome may be the earliest clinical manifestation of Hodgkin's disease. The possibile value of alcohol sensitivity as a guide to therapy should be considered.

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A Study of Chlorothiazide (Diuril®) as an Adjunctive Antihypertensive Agent

WILLIAM H. BUNN, JR., M. D.

Historical Introduction

HYPERTENSIVE patients in congestive failure may demonstrate a marked hypotensive effect coincident with drug induced diuresis. Laboratory data has been brought forth suggesting that arterial blood pressure is affected by the blood volume and degree of sodium retention. On the basis of these observations, Wilkins[1] and his associates in Boston, and a group headed by Freis[2] in Washington, set up long term studies to determine the value of diuretic agents in the treatment of hypertension.

A new synthetic diuretic, chlorothiazide ('Diuril'), was first reported in 1957 by Novello and Sprague.[3] Soon thereafter, it was demonstrated to be a potent diuretic and saluretic agent in both animals[4] and man.[5] When chlorothiazide was studied for its antihypertensive activity, it was found to be quite effective, especially when combined with other blood pressure lowering agents.

Mode of Action

All investigators seem to concede that at least part of chlorothiazide's action on blood pressure is mediated through its salt depleting action. Chlorothiazide is a more effective saluretic agent than any other known diuretic agent in the nonedematous patient.[6] Collateral evidence to support the salt depletion mode of action exists. An excess of salt intake overcomes the antihypertensive effect of chlorothiazide,[6] and conversely, salt restriction enhances its effect.[7]

Chlorothiazide may also have an intrinsic and direct hypotensive effect when used alone. Wilkins[1] and Freis[2] both demonstrate this in clinical studies. The lowering effect may be noted in patients before there has been enough time for a salt diuresis. The drug seems to manifest some specificity, not exerting any hypotensive effect on normotensive individuals.

There has been other speculation on mode of action of the drug. Wilkins[7] suggests that chlorothiazide may in some manner decrease the pressor substances in the body such as renin. Harrington[9] has very aptly demonstrated that chlorothiazide causes a decreased excretion of mecamylamine into the urine secondary to its alkalinizing effect. Consequently, it potentiates by increasing the serum level of the blocking agent. This effect, however, is only temporary. Perhaps all of these factors enter into a given situation to a greater or lesser extent. No one theory can satisfactorily explain all situations.

The Author

● Dr. Bunn, Youngstown, is a member of the teaching staff of Youngstown Hospital Association.

Control Period*

We have in our practive approximately 55 patients under treatment with chlorothiazide for hypertension. There is adequate follow-up in 48 cases to include them in this preliminary report. The patients ranged in age from 39 to 75 years, the mean age being 59 years. There were 22 males and 26 females included in our group. All had a primary diagnosis of essential hypertension. All but one had systolic pressures recorded at 200 or more at some time, and all had documented diastolic levels of 110 or more at some time during the control period. Only two patients had complicating congestive failure, and one had known azotemia. All blood pressures were recorded in the doctor's office in the sitting and standing positions.

During the control period, 44 of the 48 patients studied were under constant treatment with single or multiple antihypertensive drugs. Four patients had no treatment during the control period; 18 were taking reserpine alone; 13 were being treated with a combination of reserpine and hydralazine; 3 were on reserpine and blocking agents; 9 took reserpine, hydralazine, and blocking agents at some time during the control period; and the one sympathectomized patient was taking blocking agents.

The average control period for the studied group was 4.6 years. Extremes ranged from only one observation in four cases to as long as 14 years in one case. During this control period, the patients were seen on an average of 28 visits.

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*Blood pressure readings for this control period were obtained from the private files of William H. Bunn, Sr., M. D., and John A. Rogers, M. D.

Study Period

After adding chlorothiazide** to the regimen, the patients under study were followed for an average of three months, extremes ranging from one to six months. Five were observed on only one occasion, the others being seen from 2 to 14 times. The average was four visits.

Chlorothiazide was used in doses ranging from 0.5 grams to 2 grams daily in divided doses. The largest group of patients, 35 in number, were taking a combination of reserpine and chlorothiazide; three took chlorothiazide alone; nine were under treatment with chlorothiazide combined with blocking agents with or without reserpine; and one was carried on Apresoline® and chlorothiazide together. In a number of instances the dose of blocking agent or reserpine was reduced during the study period without loss of favorable effect.

In lieu of the fact that the majority of patients were extensively treated during the control period, reduction of blood pressure during the study period was quite impressive. All 48 patients showed a systolic pressure drop with an average of 23 millimeters of mercury. Forty-four demonstrated lowering of the diastolic pressure with an average of 11 mm. hg. The systolic drop ranged from 2 to 55, and the diastolic from 1 to 23. It is of further interest that 21 patients who had been previously treated and observed over adequate control periods recorded the lowest systolic and/or diastolic readings ever obtained after addition of chlorothiazide.

Side Effects

Side effects occurred in 26 patients, but were generally less serious than with any antihypertensive previously used in our practice. Only two patients (not included in the study) were unable to tolerate the drug at all. Three others had to reduce the initial dose due to side effects. The majority tolerated the drug quite well, many of them reporting a general feeling of well-being.

Of the side effects noted, a frequent symptom was the development of nocturia in six patients. To offset this group, however, there were five patients who reported the loss of previously existing nocturia. Five individuals reported sleepiness while six others voiced complaints of no pep, being tired, less drive, and laziness. There were six who had complaints referable to the gastrointestinal tract with nausea, cramps, diarrhea, and even severe vomiting in two of these instances. Three patients had complaints referable to postural hypotension. There was one instance each of headache, leg aches, generalized aches, memory loss, pounding heart, excessive thirst, thrombosed retinal vein, and one bigeminal rhythm in a patient taking digitalis.

DISCUSSION

Review of Previous Studies

Clinical investigators generally agree that lowering of blood pressure in uncomplicated hypertension is desirable, if reasonably tolerated by the patient. Chlorothiazide has been proven to be a valuable adjunct to previously used antihypertensive agents, as illustrated in the recent medical literature. Wilkins[1] states that this drug is of real value, particularly when coupled with a ganglionic blocking agent. In a group of 23 patients studied by him, 19 responded with an average blood pressure drop of 32 mm. systolic and 21 mm. diastolic over previously treated control levels.

Freis[2] has followed a group of 73 patients who had previously been under treatment with a variety of antihypertensive agents. He found that 69 of these responded with an average further reduction in blood pressure of 16 per cent after chlorothiazide was added to their regimen. He was able to reduce the dose of the other antihypertensive agents in some instances and even entirely eliminate them in others, without sacrificing the blood pressure lowering effect.

Heider[8] added chlorothiazide to the regimen of patients who had previously been well controlled on a combination of reserpine and mecamylamine. There was further significant reduction in the blood pressure of 18 of the 23 patients so studied. In 10 of these cases the dosage of blocking agent was able to be reduced. In all clinical studies, it was obvious that previously sympathectomized patients were predictably and markedly sensitive to the hypotensive effect of the drug.

Significance of This Study

Our study deals with a group of patients followed over a long period of time. They had been treated with a variety of antihypertensive agents. Prior to the addition of chlorothiazide, the results had not been consistently satisfactory. Some of the patients experienced serious side effects. This frequently necessitated reduction in the dosage or even discontinuance of the offending agent. Some of the patients had shown initial dramatic response to the various drugs or combinations. However, eventually they would demonstrate escape effect. After the addition of chlorothiazide to the regimen, there was observed a rather constant and sometimes dramatic lowering of the blood pressure.

In contradistinction to previously reported

**Supplied as Diuril® by Merck Sharp & Dohme.

studies, the majority of the cases in our group were on a combination of chlorothiazide and reserpine. Although our follow-up data has been brief and not finally conclusive, the trend seems to be quite significant. There has been no suggestion as yet of escape from the effect of chlorothiazide. Although most of the patients had been previously extensively treated with other drugs, many attained a lower pressure reading than at any time in the lengthy control period.

The side effects experienced were in line with those previously reported in other studies. Postural hypertension was present in a number of our patients during the control period. This was not accentuated by the addition of chlorothiazide. A number of the patients experienced a "washed-out" feeling when their blood pressure was suddenly and markedly reduced. If therapy was continued, however, they seemed to gradually adjust to this new situation, and eventually regain their vitality despite the fact that the blood pressure remained at lowered levels. This effect could probably have been prevented by initiating chlorothiazide dosage at a lower level and gradually increasing as tolerated.

One of the most common side effects in our study was nocturia. This probably arises from the concomitant diuretic action of the drug. An equal number of patients, however, completely lost previously existing nocturia after the institution of chlorothiazide. When nocturia did occur, we found that we could sometimes eliminate this annoyance by giving the last dose of chlorothiazide in the afternoon instead of at bedtime.

Precautions Regarding Azotemia And Hypokalemia

Patients who have compromised renal function must be treated cautiously with chlorothiazide. In the case of the sympathectomized patient, addition of the drug brought about a marked hypotensive effect (blood pressure 100/70) with coincident rise of the nonprotein nitrogen from 40 to 88. This effect disappeared with temporary discontinuance of the drug, and reinstitution at a lower dosage level.

In almost every instance, our patients have been placed on daily supplements of orange juice or potassium chloride. Wilkins[10] points up the frequent measurable depletion of serum potassium in patients on chlorothiazide. He cites five instances of sudden death. These patients either had advanced coronary artery disease or were taking digitalis. He postulates that death might well have occurred due to arrhythmias which developed with lowered potassium levels. He recommends administering 1 to 4 grams of supplemental potassium. He also advises against rigorous salt restriction, as it further favors potassium excretion by the kidney.

Conclusion and Summary

We have presented a group of 48 patients previously treated with a variety of antihypertensive agents. These patients had a significantly lengthy control period.

Upon the addition of chlorothiazide to their regimens, there was realized an additional blood pressure lowering effect of 23 mm. systolic and 11 mm. diastolic.

Side effects were not serious but caution must be exercised in the treatment of patients with already compromised renal function.

Concomitant administration of oral potassium seems to be indicated.

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The Role Played by Normal Human Microbial Flora

Perhaps the time has come for us to renew our studies of normal human microbial flora and the manner in which it may shield our bodies from invasion by dangerous or harmful organisms. Surprisingly enough, little is known of the dynamic equilibrium which is maintained in our bodies by these unseen guests. Each of us harbors a population of bacteria numbering well into the trillions. They take up residence shortly after our arrival on the earthly scene, and they quickly populate our internal and external epithelial surfaces, remaining with us through thick and thin, until death closes down the boarding house and they in turn, are forced either to die or to depart. —Herbert H. Kersten, M. D., Fort Dodge, Iowa: *J. Iowa M. Soc.*, 48:240, May, 1958.

Aniseikonia — Four Case Reports

DONALD G. ALLEN, M.D.

ANISEIKONIA may be briefly defined as a condition in which one eye sees an object larger than the other. Symptoms are the usual ones for eyestrain, but an occasional patient has space disorientation, with or without other symptoms.

Three recent new cases and one old one illustrate so well the typical findings in examinations for aniseikonia that a report may be of interest.

Case Reports

Case No. 1: A 30 year old woman, office worker, never has worn glasses. Complaint: Poor vision left eye—vague discomfort. Fundi, muscles and tension normal.

Vision:

6/5 c̄ + 0.12 ⊂ + 0.25 × 80 6/5
6/12 c̄ + 0.75 × 120 6/5
(mydriatic)
RX less + 0.12

From the beginning she reported difficulty in judging distances on her desk and also tilting of steps and floor, with the glasses. Space eikonometer examination showed that a 0.5 per cent meridional size lens × 135 O.D. equalized the right and left images. A second examination one week later gave same result. However, at this time she reported that the troubles had disappeared, therefore no size correction was given.

Case No. 2: Secretary in her middle 30's. Complaint: Car sickness, dizziness in looking back and forth at her notes on her desk. Other findings negative; reported by her ophthalmologist.

Vision:

c̄ — 4.50 ⊂ — 0.50 × 10 6/6
c̄ — 2.50 ⊂ — 1.25 × 82 6/6

Symptoms and difference in correction both suggested aniseikonia. The eikonometer, however, showed "0" size difference with repeated examinations.

Case No. 3: A 58 year old man, referred by family physician who had had similar symptoms relieved by correction for aniseikonia. Complaint: Right supra-orbital headaches—6 months, almost constant. Fundi, tension and visual fields normal.

Vision:

6/15 c̄ + 1.50 ⊂ + 0.25 × 165 $6/4^{6}$
6/15 c̄ + 1.50 $6/4^{6}$
Jaeger I c̄ + 2.50 add O.U.
Right hyperphoria 1°

This man had been wearing

+ 0.50 ⊂ + 0.50 × 80
+ 0.50 ⊂ + 0.25 × 100 add + 2.50, O.U., for 1½ years.

The eikonometer showed "0" size difference c̄ 0.5% discrimination.

Glasses were prescribed:

+ 1.50 ⊂ + 0.25 × 165 ⊂ ½° prism base down
+ 1.50 add + 2.50 O.U. Trif.

One month later he reported complete freedom from headaches. The trouble apparently was caused by an undercorrection.

The Author

● Dr. Allen, Cleveland, is chief surgeon, De-Department of Ophthalmology, Fairview Park Hospital.

Case No. 4: A 28 year old woman, housewife. Complaint: Headaches with close work. Fundi, tension and muscles normal.

Wearing — 2.50 ⊂ — 1.00 × 180
— 2.25 ⊂ — 2.00 × 165

Vision:

5/60 c̄ — 1.50 ⊂ — 1.75 × 5 6/5 (mydriatic)
4/60 c̄ — 1.50 ⊂ — 1.75 × 160 6/6 "
RX given in full.

This patient was seen again three years later, and reported freedom from headaches. However, she was learning to drive and always crowded the curb when parking. The refraction was essentially the same. One would not suspect aniseikonia from the RX and it is not unusual for a new driver to have parking troubles. However, a test was made on the eikonometer. The images were equal with this magnification:

0.7% × 61 right eye
0.2% × 151 left eye

This correction was included in her prescription after a partial correction with a fitover size lens improved her space localization. At last report she had much less trouble parking.

Comment

Case 1: Illustrates the point ~~that~~ the eyes (brain) themselves often compensate for a definite size difference, which therefore needs no correction.

Case 2: Brings out one of the disappointments in this work. She should have had a size difference caused by the unequal correction, but didn't. I intend to try an arbitrary correction calculated from the lens powers, as she still has difficulty.*

Case 3: This case shows the value of a careful refraction and *full correction*. Aniseikonia did not enter into the picture. The ½° vertical prism may or may not have helped.

Case 4: This is a true case of aniseikonia, unsuspected because of the similar right and left corrections, and brought out by the typical space disorientation while learning to drive. Cases like this are few and far between, but are the ones that keep a person interested in the eikonometer.

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*Since this was written, the calculated size correction has been tried with no relief of symptoms.

Heart Block Immediately Postpartum (Report of a Case)

N. M. CAMARDESE, M. D.,* Norwalk, Ohio

THIS is a report of an interesting case of heart block occurring in a healthy white woman, 28 years of age, and with no history of any previous heart disease. She has had five children. Her system review is negative.

Physical examination was within normal limits including blood pressure and weight.

The patient started in labor about 6:00 a. m. At 9:00 a. m. she was given 50 mg. of Demerol,® ¾ gr. of Seconal® and 1 cc. of Phenergan®. Atropine was specifically omitted because delivery was planned under saddle block anesthesia. The omission was to avert the much complained about dryness of the mouth. One cc. of heavy Nupercaine® was used for the saddle block. Good

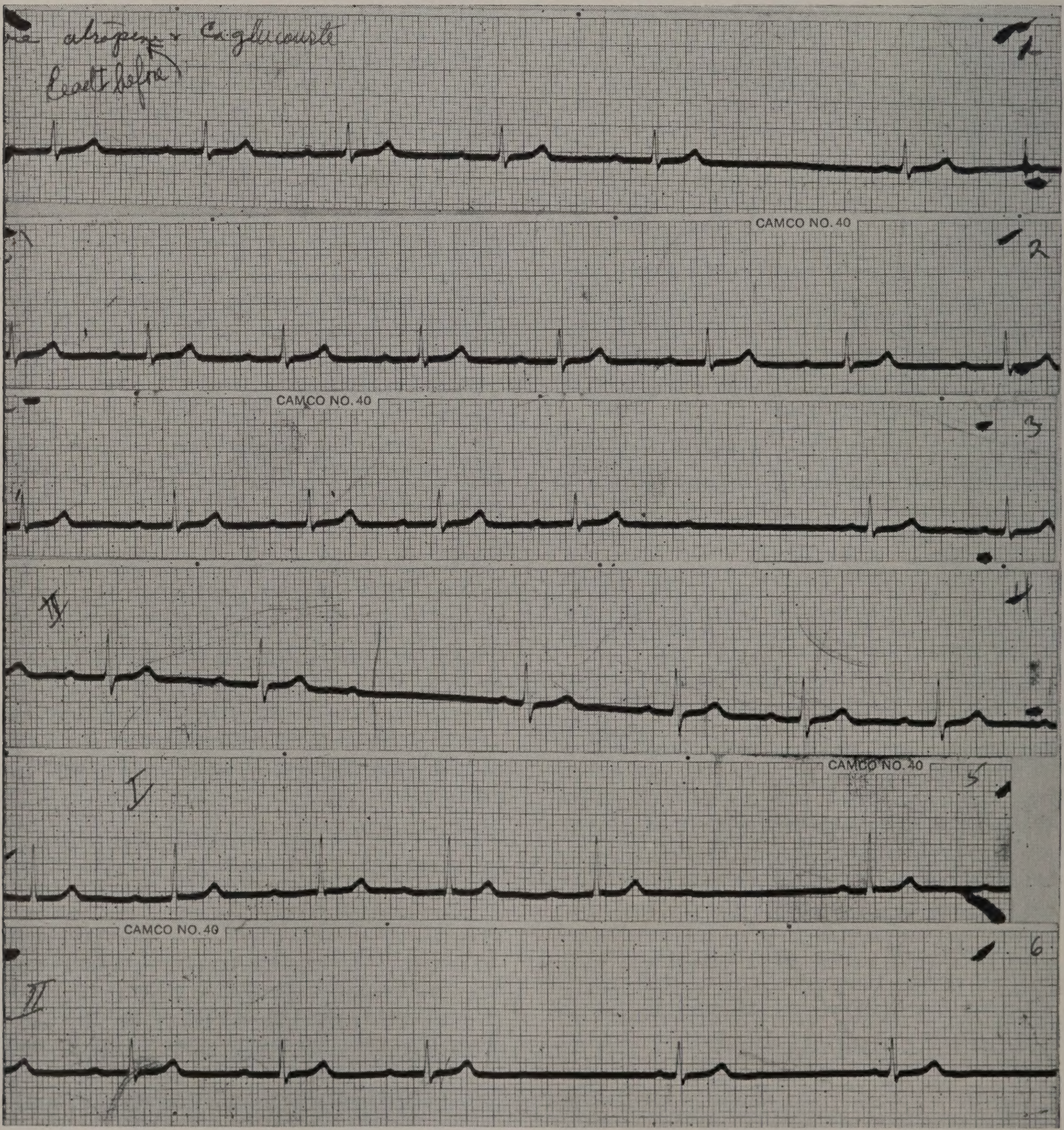

FIG. 1. Note the progressive prolongation of the P-R interval from .12 to .30 sec.. (Wenckebach phenomenon) before administration of Atropine.

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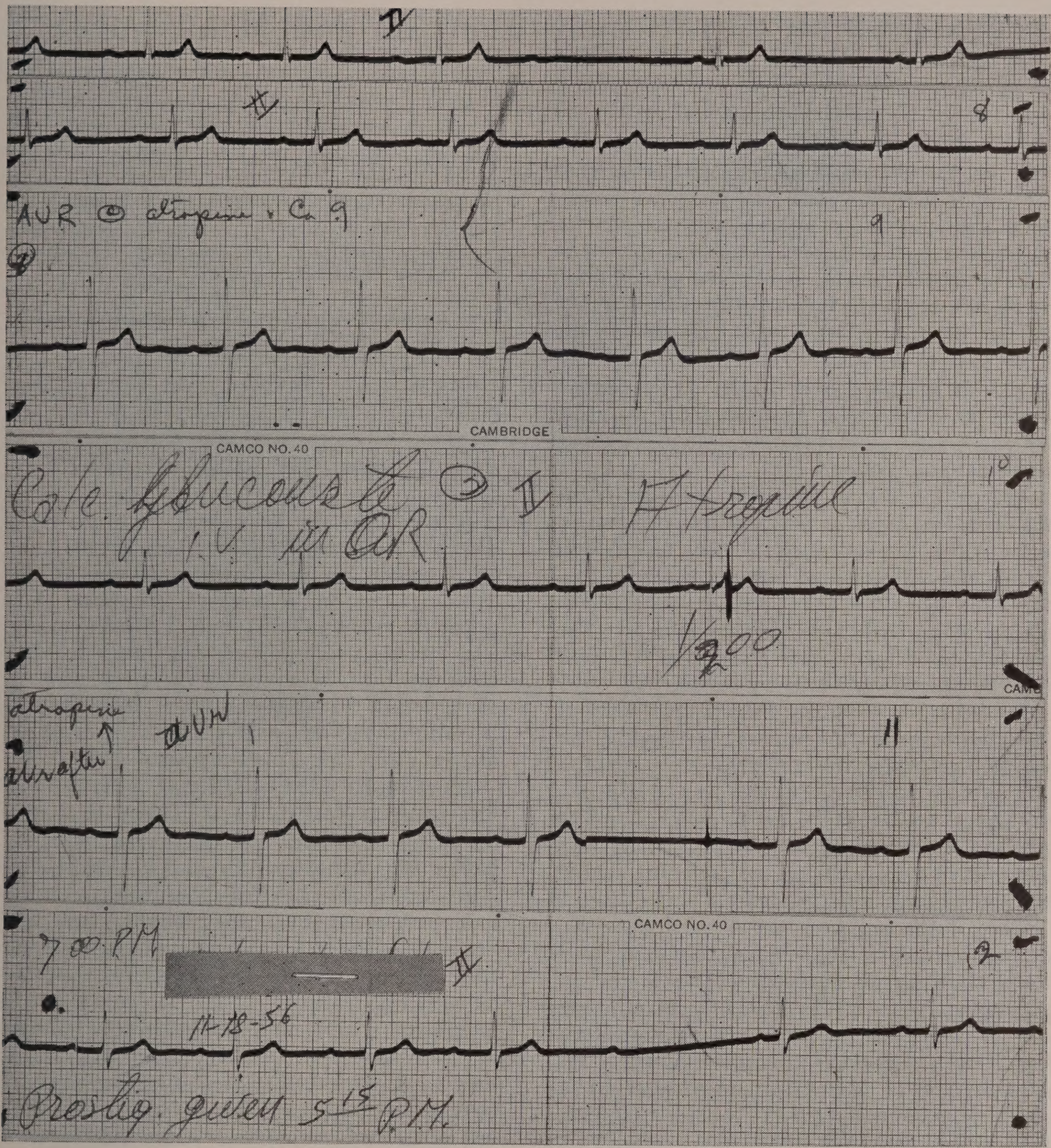
*Dr. Camardese is secretary of staff at Memorial Hospital in Norwalk.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12
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Prostig. given 5 15 P.M.
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FIG. 2. After administration of i. v. Atropine (3rd tracing from top) the P-R interval is constant (.17 sec.). Block again recurs after administration of Prostigmine (bottom tracing).

anesthesia was obtained without any complications whatever. A low forceps, uncomplicated delivery was accomplished.

About one hour after delivery, patient complained of dizziness and felt like vomiting. Blood pressure was 110/70 (no drop) but the pulse was rather irregular and very slow. Not having an electrocardiograph in our little hospital at the time I rocketed to and from my office, got my electrocardiograph and the tracing showed a beautiful case of Wenckebach phenomenon with occasional complete atrial asystole and ventricular rate as low as 28.

Ephedrine ½ cc. and 1/300 gr. of atropine were given intravenously (with a running tracing). Immediately the pulse reverted to normal.

Eight hours later the patient complained of cramps and there was considerable abdominal distension. One cc. of Prostigmin® was given subcutaneously. Within five to ten minutes the heart block recurred and again it was corrected instantly with atropine intravenously.

A tracing eight weeks postpartem shows no aberrations.

Practicalities of Ileostomy Function and Management

PAUL T. CARROLL, M.D.

THE majority of patients who undergo surgery for intractable ulcerative colitis or multiple polyposis will, in the postoperative period, be confronted with the management of an abdominal ileostomy. In most cases the ileostomy is permanent and rarely if ever will continuity be restored. Following excision of the rectum the patient is left with but little choice other than to completely familiarize himself not only with the physiology of the newly formed stoma but furthermore he must learn to adapt himself socially, economically, physically, and mentally to an ileostomy life.

The patient, having sufficiently recovered from the operation, becomes not only confused but at times rather despondent as to how to conform to this altered method of bowel evacuation. Provided the stoma has been properly constructed it should work well and without difficulty. The problem now resolves itself into one of how well will the patient work with the stoma.

Instruction in ileostomy management must of necessity begin in the immediate postoperative period. Explanation concerning ileostomy function and care can be afforded by the nursing staff, the operating surgeon and referring physician. The patient can learn much from frequent interviews and conversation with trained personnel during his postoperative convalescence.

Once discharged from the hospital, however, the management of the ileostomy is now the sole responsiblity of the patient for he is for all practical purposes on his own and out of direct contact with the instructors. Having returned home the patient faces life anew. What is his adjustment to be like? How and to what extent can he become rehabilitated? How practical, how forceful, and with what attitude toward the future may he face the world before him?

It is the sincere hope of the author that the following guide written in plain, simple language may serve as an everyday reference for patients with an ileostomy about to leave the hospital. Local doctors and family physicians as well may find it of some use. The text is phrased in a subjective manner.

The physician's remarks are directed toward the patient:

"The Ileostomy, Its Function and Care"

You are about to undergo a change in your daily living. It is not a change for the worse but moreover, a change for the better. The small, tube-like projection on the right side of your abdomen is an "ileostomy." The large intestine or colon, the cause of your previous sickness and diarrhea, has been surgically removed together with the rectum. The rectum was removed because it too was destroyed beyond repair.

In order that the body wastes may be amply disposed of, it was completely necessary to bring the terminal end of the small intestine to the outside so that the products of body waste could empty by means of this newly formed "rectum" into the bag which you are now wearing. Your ileostomy then is, in truth, no more than an altered mode of having a bowel movement. It is something to which you will have to adjust to, yet it is nothing to be ashamed of.

Many people like yourself have gone through the same period of curiosity, anxiety, depression, discouragement, and have expressed the same hidden fears and despair that you are undoubtedly experiencing. Let me tell you that these people are today very much alive, happy, healthy, busy, and are enjoying life as normal citizens in every respect. Certainly, there is no reason for you not to be one of them.

Yes, there are some problems involved in the care of your new ileostomy; problems which may on occasion become serious if you are not equipped to cope with them. Please do not give up; things may seem difficult at first only to work out very well with a little energy, time, and patient understanding. Remember this much, the success or failure of the operation is entirely dependent upon your ileostomy and how it performs for you.

In the beginning the Doctor and Nurse can help a great deal in teaching you the intricacies of ileostomy function; later, however, when you are discharged from the hospital the job is entirely within your hands. Be patient and be sensible. Take a realistic attitude toward your ileostomy; learn all you can about it and it will work well for you. A properly functioning stoma will reward you with a return to normal living in every respect and you may take your place amongst

The Author

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your family, friends, and relatives uninhibited. Your life once again can be your own. Cheer up, you are going to live as a healthy, normal person.

To help you with some of the minor problems which may trouble you in the early period regarding your ileostomy and its care, the following material has been compiled. Read it over carefully and memorize it as it is your basic guide. Take it with you when you leave the hospital and study it over again at home. It has helped others a great deal and it will help you!

A. Ileostomy Care

(a) Behavior of the Stoma or Opening

The discharge from the opening will at first be runny, thin and watery-green. Later it will thicken up and become much like the consistency of normal bowel movement and will have about the same odor. An occasional watery movement should not alarm you. The stool rather tends to be thin in the morning, thickening as the day passes and as more meals have been taken. In general, foods with high residue content make the stool more solid. There may be a little blood in the stool during the first week in the form of small flecks. When the stool passes through the wall of the ileostomy the stoma may squirm or contract; this is normal.

(b) Foods Seen in the Ileal Discharge

At times the ingestion of corn, coconut, nuts, or bean pods; seeds, prunes or other high residue foods may appear at the opening. This simply means that the body does not wish to use these foods and is excreting them. If pain or distension should accompany the passage of these foods it may mean that the opening is partially blocked. It is then only necessary to insert a finger into the opening, or a well oiled, soft rubber catheter may be inserted into the ileostomy and gentle irrigations be carried out by means of warm tap water. A cupful is usually more than adequate for irrigation. The color of the stool may vary with the type of foods ingested. Remember, beets color the stool red and can be mistaken for blood!

(c) Odors

Usually the stool has the odor of a bowel movement. Some fish foods, eggs, prunes, or heavy alcohol intake may at times create a very unusual and offensive odor. There is usually no offensive odor, either from the ileostomy or the bag, which could be detected by others.

(d) Amount of Ileal Discharge

The amount and volume depend to a large extent upon the quantity and variety of food ingested. Eat as much as you like, but expect more ileostomy discharge. If the discharge becomes profuse, watery, and remains so for an indefinite period of time, it is well to get in touch with your physician. This may signify trouble!

(e) Time of Passage of Food

The time required for ingested food to appear at the ileostomy opening varies. During the day in normal activity the meal takes about four to five hours to pass, however, during sleep when all bodily function is materially slowed, 10 to 12 hours is not uncommon. Therefore, one should not be alarmed to find the ileostomy bag fairly full during the waking hours of the morning.

(f) Control

There is no control to the ileostomy as there is no muscle by which control could be initiated. The contents normally flow from the opening at a slow, constant rate necessitating wearing the bag at all times, except for periods of cleaning the bag.

(g) Emptying the Bag

It is best to empty the bag only when it becomes absolutely necessary to do so. That is, when the bag becomes full of gas, discharge, or bowel movement. Once the bag is in place it should be left alone. Frequent changing is not recommended and may do harm.

(h) Care of Skin

During the first few weeks following surgery you may have minor difficulty with skin rash or excoriation of the skin about the ileostomy. Thorough cleansing of the skin before applying the bag is a most essential prophylaxis. Be sure that the bag fits securely upon the skin. When you are confronted with a frank irritation, it is sometimes judicious to remove the bag for a three to four day period using a protective powder or cream on the skin. For this, Desitin® oinment or karaya powder is most helpful. Some people are sensitive to rubber or cement. In this respect the bag will have to be altered or a change to the plastic or Perry bag will have to be instituted.

Irrigations sometimes are of help as incomplete emptying of the ileostomy will give rise to a constant, irritating seepage which tends to digest the skin. If you are unsuccessful after having tried these varied measures, have your doctor check the bag and the ileostomy. Talk the problem over with him.

(i) Diet

You may eat any food which you desire. In general, avoid high residue foods. You will come to realize that some foods are apt to cause gas, cramps, flatus, and diarrhea—avoid them. Eat slowly, and thoroughly chew your food. Do not overeat. Avoid beer; however, an occasional cocktail is perfectly harmless. Eat between meals if you so desire. You will gradually learn by trial and error that you can eat almost anything.

(j) **Appetite and Weight**

Most of our patients acquire a good appetite in the immediate postoperative period. The weight gain oftentimes is dramatic, and in some individuals the weight has to be controlled by dietary measures. A rapid gain in weight may at times interfere with ileostomy function. Regain your normal weight, but refrain from becoming obese.

(k) **Intake of Liquids**

You may become very thirsty—drink all of the water you desire; drink slowly and avoid iced or hot beverages. Some of our patients drink 8 to 10 glasses of fluid per day. It is fine, the body needs it.

(l) **Episodes of Pain and/or Distension**

You may experience pain, bloating, or lower abdominal distension from time to time. This is usually because of improper dietary habits or over-eating. Sometimes it is due to food particles partially blocking the opening. Finger dilatation or tap water irrigations are recommended and usually will relieve the disorder promptly.

(m) **Sleep**

In the beginning your bag may not fit properly with the tendency toward soiling the sheets during the hours of sleep. You can expect this initially, especially too when the contents are thin and watery. We advise our patients to use rubber sheeting over the mattress. Position is not important and will not prevent soiling. Get at least eight hours sleep and be in the position most comfortable to you. Turning, twisting in bed, or lying on your stomach will do no harm. Expect some soiling early; it will not last forever.

B. General Adaptation to the Stoma

You should now realize that a properly functioning stoma is in no way incapacitating. Once you have learned to care for it, it becomes a part of you as in any other organ of your body. Should you be inhibited? Are you to become a shut-in? Certainly not; not in the least! What can you do? You can do anything! Talk to another patient; ask him and see what he says. Join your local ileostomy club and attend its meetings. You will be more than surprised.

The following comprises a list of topics of interest to you in your daily living. Other patients have asked about them; here is what they have had to say:

(a) **Education and Vocation**

Patients are returning to school. One patient has become a doctor; another has attended trade school. Classes can be well attended and there has been no embarrassment; no impairment of the mind or the ability to study and do good work has ever been complained of.

(b) **Social**

The bag can be worn under any type of clothing, even under form-fitting attire, unnoticed. You should be able to attend any social function and take your place among the guests as one of them. There will be no odor, so do not worry.

(c) **Marital**

Our patients are getting married and are having happy families. Six of our patients have had normal children delivered in the same manner as any other mother. Only one of our male patients out of 40 has become impotent. One patient is soon to become a father. Coitus and sexual relationships can be carried on in normal fashion; no precautions are needed. The bag should be left on during intercourse as a rule.

(d) **Clothes**

Wear any type of clothing you desire. If helpful to you, wear a support or girdle over the bag. No harm will come from this.

(e) **Travel**

Patients may travel, ride in a car, train or bus for long distances. If you plan to be away for a long period of time stock up on extra equipment. Take along extra bags and straps. It may be judicious to take along some rubber sheeting as well. Protective skin cream and irrigation catheters may come in handy.

(f) **Athletics**

Our patients are indulging in minor sports and are enjoying them. Tennis, skating, bowling, horseback riding have all been undertaken. Bathing and hikes are permitted also. Contact sports as a rule are not advocated.

(g) **Jobs**

Work at any job to your liking. Pursue any career that you choose. One of our patients has his own garage; another is a traveling salesman; a third female patient is an active housewife and mother.

(h) **Insurance**

This has been a touchy question in the past, however, the door is open to you for all types of insurance but with some policy modifications and reservations.

(i) **Health and Accident**

You may obtain health and accident insurance, however, a rider clause may be attached to your policy.

(j) **Life Insurance**

You may as an ileostomy patient obtain life insurance, but the premium may be at a higher rate. Later as your condition remains good you may have the chance to become re-classified with the premium rate revised downward.

A Child Health Survey

Part II: The Methods by Which Addyston Met Its Child Problems

R. A. LYON, M. D., LOUISE W. RAUH, M. D., C. A. WEIHL, M. D.,
F. W. KELLOGG, M. D., and KATHRYN D. LAVRICH, M. D.

THREE sources of information provided estimates of the health of children in the Addyston survey. Examinations of children in the school were made by nurses and doctors, conferences were held with teachers and parents and a house to house canvas was carried out over a three month period. The techniques employed and the defects found have been discussed in a previous report.[1] The abnormalities of health which occurred with the greatest frequency were those usually encountered among children of middle economic groups. Seven of these most common conditions, dental caries, eye and ear defects, heart disease, malnutrition, tuberculosis and behavior disorders were selected for further evaluation and especially in regard to the facilities in the community for their diagnosis and care. This report summarizes that part of the survey.

The Dental Situation

The incidence of dental caries, as discovered during the doctor's examination seemed high for this age group. More than 50 per cent of the children had readily apparent cavities. Had a dentist examined the teeth carefully with mirror and probe, he would have found many more children who needed attention.

No dentist resided in Addyston and only one in Cleves, the adjoining town. To secure dental care the children of this area had to go a long way to see a private dentist, and if clinic care was obtained, the distance was about 25 miles, the time for transportation alone being two to three hours.

Immediately following the survey the Addyston health committee inaugurated a program for dental care which might be at least partly self-supporting. Through The Children's Dental Care Foundation of Cincinnati a dental chair and equipment were donated. Room for the dental equipment was provided at the school and the additional funds for installation were secured from parent-teacher groups, an industrial plant and the Cincinnati groups. More difficult at the onset was the staffing of the clinic, but a practicing dentist offered a half day each week and a small sum was provided for this part time work.

This problem of the establishment and staffing of a Dental Clinic for children was discussed frequently by lay and professional groups. They concluded that guidance and supervision should come from the dental profession but the responsibility for support seemed to lie with tax supported institutions such as the village or county, or with charitable organizations concerned with health problems of children. A third procedure, favored by most of the committee, was the reduction of overhead costs to a minimum so that professional services and supplies might be paid for by the patients themselves.

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Eye and Ear Defects

There were 46 children (14 per cent) of the group who had eye disorders, usually defective vision, but occasionally squinting or ptosis of the lids. A total of eight children (2 per cent) had defective hearing or chronic infection of the ear. Almost every one of these children required the care of specialists who had offices or clinics in Cincinnati. There was no evidence of inability on the part of the patients to secure needed consultations and the nursing and teaching staffs had been very cooperative in encouraging the pupils to follow the medical instructions. There seemed to be no need for the visiting physician or survey group to add to or change this program.

Heart Disease

Information regarding heart disease and rheumatic fever was obtained from three sources: the physical examination, questionnaires sent to parents, and from medical data collected previously by teachers and nurses of the school. Examinations were made with the pupil in erect and in recumbent positions. Whenever questions arose regarding the nature of a murmur, more than one physician examined the child.

Among the group of 322 children ranging in age from 5 to 16 years, only one child had a definite loud murmur due to an abnormality of the heart, in this case a congenital heart deformity. This child was under the care of his private physician and was making regular visits for observation. The occurrence of one child with a definite murmur among 322 children was exactly the rate (0.3 per cent) expected from previous surveys made of school children in Cincinnati a few years ago.[2]

In addition, there were 36 children (11 per cent) with heart murmurs which were faint and inconstant, all diagnosed as functional or inconsequential murmurs and not representative of abnormality of the heart. Since such murmurs occur frequently in children and may be a cause of unnecessary alarm by patient and their parents, the observation was recorded on the patients' charts but no mention of heart disease was made to the children or their parents. The children will be kept under observation but no treatment or restriction of activity was advised.

Finally there were four children who had a history of rheumatic fever at some previous date but had no residual heart damage. One of the children had been a patient at The Cincinnati Children's Hospital and was being followed there at regular intervals and was receiving prophylactic treatment to prevent recurrence of the disease. Others had less definite histories and were in excellent health. Since the information of the symptoms came from the parents, the children were referred again to their doctors and efforts will be made to have them observed regularly by these physicians in their offices or clinics. (Table 2).

TABLE 2.—*The Incidence of Murmurs Among 322 Addyston Children*

Congenital Heart Disease	1
Functional, inconsequential murmurs	36
Total	37
History of rheumatic fever, but no murmur or heart damage	4

The Nutritional Problem

There were 25 children (8 per cent of the group) who were considerably underweight or overweight (below the 3rd percentile or over the 90th percentile on the Anthropometric chart of the Boston Medical Center). The 15 who were unusually thin were mostly boys who were alert and active and had apparently been leading normal, healthy lives. To be certain that there was no organic disease in the background, one physician of the survey group returned to the school on several occasions to examine these children more carefully; to check their medical records for evidence of previous disease; to interview their parents and finally to test the urine for albumin and sugar, and the blood for evidence of infection or anemia. No abnormalities were discovered. The nurse planned to make regular measurements of height and weight to observe their trends over longer periods of time.

The 10 overweight children were mostly girls of pre-adolescent ages. At first the staff planned nothing for this group but upon learning that some of the children were interested in discussing diets, arrangements were made for the chief dietitian of the Cincinnati General Hospital and one of her student interns to meet with the pupils. This activity was carried out as a project of the Community Nutrition Section of the Cincinnati Dietetic Association and it was interesting to note that 18 children, more than the number selected by the doctors, asked to be included. The conference was devoted to a discussion of balanced diets emphasizing the "basic seven" foods, with added suggestions for gaining or losing weight. Charts were given to the pupils, a display card was presented to the school and check lists of the basic seven foods were sent to the nurse for distribution.

Tuberculosis

Examination for tuberculosis included routine patch tests, measurements of the height and weight of the children for evidence of malnutrition and occasionally examinations of the chest, although very little reliance was placed on the presence or absence of abnormal lung sounds as diagnostic signs of tuberculosis in children. Questionnaires to parents, nurses and to teachers sought information regarding tuberculosis in families and unusual symptoms of fatigue or malnutrition among parents or children.

Thirteen children had positive tuberculin patch tests. All but three had been known as positive reactors by parents and the nurse at school. X-rays had been made of the children's chests and the course of the infection had been followed regularly in the local chest clinic, a facility Addyston is fortunate in having.

One child with a newly discovered positive test caused immediate concern to the parents and before the day was over, the mother had taken the child to Cincinnati for an x-ray of his chest, which was reported free from any sign of active infection.

An additional 15 children were underweight as determined by comparing their measurements with standard charts. Others were described by parents and teachers as sleepy, inattentive and frequently tired. When these children were examined at a later time, no evidence of tuberculosis could be detected.

The rate of positive tuberculin reactors was about 4 per cent, a figure midway between the 0.7 per cent found in suburban Cincinnati and 7 percent found in the congested basin areas of the city.[3] Of considerable importance was the ease with which the tuberculin patch test was performed and its effectiveness in selecting children and families for further investigation.

Behavior Problems

There were 19 children (6 per cent) reported by the teachers to have abnormalities of behavior. Many of the disorders were mild and were manifested chiefly by flagging interest and energy in school work. Others had deep seated problems of adjustment and behavior, often associated with disturbed home environment. A few of the families of the delinquent children were known to social agencies in Cincinnati, but none of the children was receiving any psychiatric guidance. The survey staff was undecided about the advice to give the community regarding treatment of this problem.

It seemed likely that this group of children had been living for such a long time in poor home environments, under conditions of broken or misguided family life, that it would not be easy to effect any changes in behavior unless the families experienced a definite desire for help and guidance. It was suggested that a program devoted to guidance of the brighter children of the school to encourage them to continue school work or to secure specialized education might bring greater rewards than attempts to lift those of lower levels to acceptable social standards.

As a trial project, one family containing delinquent members was investigated thoroughly to search for causes of abnormal behavior of the children. Using such information the survey group planned to meet with the teachers and discuss the problems of the specific children and if possible, to make some general deductions of policies or plans to follow in developing a program of mental hygiene for the community.

Under the auspices of the Adolescent and Developmental Clinic of the Cincinnati General Hospital, a social investigator, a psychologist and a physician interviewed and examined the patient and his family and presented their findings for group discussion. One result of the conference was an increasing awareness by the family that help for behavior problems was available, and a second result was an insight into some of the conflicts existing within the community.

An important step taken by the school was the appointment of an additional teacher in order that more time might be spent by all of the faculty in caring for minor individual problems arising in the classrooms. More opportunities for conferences between teacher, nurse and doctor were advised but limitations of time and money have made it impossible so far to carry out this plan.

Reorganization of summer work opportunities and recreation activity was undertaken by the community and even if results prove to be meager at first, the interest of the community has been aroused and the attention of the community has been focused on this aspect of child health.

Discussion

The Addyston Survey was undertaken to determine the specific health problems of the children in a distant suburban area. The community was well aware of the general nature of its hygenic situation but the survey brought into sharp focus some of the most pressing problems and suggested an immediate course for correction. The presence of an intelligent health committee, eager for action, made it easy for the suggestions to grow quickly into definite plans.

Most of the physical abnormalities of the Addyston group were similar to those of children of other communities. These patients were receiving good medical care. Facilities for treating dental decay and behavior disorders were inadequate. Within a short time, however, a dental clinic had been established by the town and steps had been taken to help some of the children with problems of behavior. The survey showed that environmental factors existing in the community might be responsible for deep rooted causes of maladjustment but that first steps towards help for the children had been taken and a long-term program of mental hygiene might be built on these foundations.

The survey also indicated that repeated medical examinations in school may not be necessary in many communities. This suggestion has been made in previous reports.[4, 5, 6] Most parents in Addyston found their way to private physicians or clinics for illness and obvious physical defects of their children. The school nurse had checked the children for immunization, vision, hearing, nutrition, tuberculosis. The need for control of serious communicable disease in the school has almost disappeared.

The school physician today might spend less time in making repeated physical examinations of children, but devote more attention to the supervision of routine testing programs, and to the studies of community problems, family cultures, housing and recreational facilities as they affect the health of children. The school furnishes an excellent center of study because there the children can be observed, the teachers may be consulted and the parents invited in for conferences.

Conclusions

1. The health of Addyston children compared favorably with standards of larger, more urban populations.

2. Adequate medical care was available and most of the Addyston families were using it satisfactorily.

3. There were several health activities which Addyston is very fortunate in having such as:

    (a) An active and effective health committee.
    (b) A school whose teaching and nursing staffs are intensely interested in the health problems of the community.
    (c) An infant welfare and a "chest" clinic.
    (d) The Lower River Nursing Association.

4. The school survey exerted its greatest influence in spheres other than the detection of physical defects, namely as:

    (a) A stimulus for parents to carry out recommendations made previously by their physicians.
    (b) A goal for the completion in school of routine testing of hearing, vision, tuberculin reactions, immunization, weighing and measuring.
    (c) A review of the total health needs of the community to see what programs should be strengthened and what ones might be discarded.

5. One of the special health problems which confronted Addyston was the high incidence of dental caries. The survey urged the establishment of a local dental clinic which was started immediately and is now operating regularly.

6. Another problem faced by Addyston was the large number of behavior disorders among the children of school age. A continuous program suggested by the survey staff consisted of:

    (a) The minute study of a few of the children most seriously maladjusted.
    (b) Several conferences each year with the teaching staff to plan methods of treatment and prevention.
    (c) Communitywide efforts to stimulate physical, manual or intellectual achievements; vocational skills; health social activities.

The school responded at once by reducing teacher loads, thus encouraging individual teacher-pupil conferences and special assistance programs.

7. The majority of physical disorders of school children are detected by measurements of vision, hearing, height and weight and tuberculin testing. Reports from parents and teachers give the information regarding abnormal behavior problems of the children. Since the school nurse can carry out many of the foregoing procedures, the school physician might be most useful in serving as a health adviser, supervising the above tests and fact finding programs, and studying health needs of children against the background of family influence and community life.

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Good Data on Morbidity Needed In Current Health Studies

It is a remarkable fact that for knowledge of health we rely largely on information about death.

National mortality rates have been in existence for more than a century, but there are few good data on morbidity, and other more direct indices of health scarcely exist. Yet mortality statistics are in many respects an unreliable guide to the incidence or social consequences of diseases; for example, they would lead us to overestimate the significance of cancer of the lung and to greatly underestimate the significance of the common cold. Unfortunately it is easier to recognize the difficulties than to remedy them.

Death is a single event for which an immediate cause can frequently be given. Many episodes of sickness meet neither of these requirements, and it is not surprising that it is only for a group of notifiable infectious diseases that continuous records are available for any considerable period.—*West Virginia M. J.*, 54:171, May, 1958, as abstracted from *British Medical Journal.*

LEDERLE LABORATORIES

Lederle

A Division of AMERICAN CYANAMID COMPANY

INTEROFFICE CORRESPONDENCE

Pearl River, N. Y. 7/18/58

OFFICE DATE

TO: Advertising Department COPY TO:

ATT'N: J. D. Roberts

FROM: C. K. Howe, Sales

Jim --

Here's a question a number of our detail men have tossed at me. Why doesn't Lederle's advertising for ACHROMYCIN V Tetracycline play up higher, faster blood levels the way so many of our competitors do?

As you know, new laboratory studies show pretty conclusively that ACHROMYCIN V is unexcelled in this department.

How come we haven't turned on the heat in our ads?

C. K. Howe

CKH:ls

LEDERLE LABORATORIES
Lederle
A Division of AMERICAN CYANAMID COMPANY

INTEROFFICE CORRESPONDENCE

Noted CKH

Pearl River, N. Y. 7/21/58
OFFICE DATE

TO: Sales Department COPY TO:

ATT'N: C. K. Howe

FROM: J. D. Roberts

Charlie --

Sure ACHROMYCIN V Tetracycline blood levels are unsurpassed in the latest laboratory study. But actually how significant are any of these blood levels, clinically? It's really a matter of micromilligrams and fractional minutes! Let's not put Lederle in the position of giving this sort of evidence more emphasis than it deserves.

I think our job is to let doctors know that Lederle Research developed ACHROMYCIN V to give improved results under actual clinical conditions . . . to get a higher percentage of antibiotic to the tissues.

The fact that ACHROMYCIN V is the most widely prescribed broad-spectrum antibiotic ought to be pretty good evidence that physicians are consistently getting these results.

If your detail men will give doctors the complete story on antibiotics, I think ACHROMYCIN V prescriptions will continue to climb without any fancy blood level advertising.

J. D. Roberts

JDR:ep

Red Eye

A Case Report on Preventable Blindness

WILLIAM H. HAVENER, M. D.

A BLIND EYE is a serious loss to both patient and community. Awareness of the preventable nature of a significant portion of this blindness should help in reducing the incidence of such tragedies. The representative cases to be presented here are selected to emphasize relatively common causes of blindness which can in many instances be averted by proper, timely care.

Case Report

A five year old girl was first seen by the ophthalmologist six weeks after onset of redness of her eyes. Apparently she had been originally diagnosed as having "pink eye" and was placed on a topical antibiotic. When this was ineffective, a series of different antibiotics were used in turn—all without arresting the course of the disease. Progressively, she developed photophobia, pain, blurred vision, more severe pain, and reduction of vision to light perception. Examination showed that the original disease had been acute iritis, which had produced extensive intraocular adhesions and blocked the flow of aqueous through the pupil causing secondary glaucoma. Surgery was required to treat the glaucoma, but did not restore vision. This outcome was particularly tragic since early use of mydriatrics and steroids probably would have prevented blindness. With rare exceptions antibiotics are *not* helpful in iritis.

Discussion

Redness of the eye is a warning signal common to many diseases. Most frequently encountered are the relatively insignificant allergies and superficial conjunctival infections. Danger exists that the frequency with which minor conjunctival inflammations are encountered may engender a feeling of security in dealing with red eyes. Such an attitude will lead to regrettable delay in making an accurate diagnosis and instituting definitive therapy for the more serious eye diseases.

How can the physician be sure he does not overlook presence of one of the serious and potentially blinding causes of red eye? Almost never will a really serious red eye not show the presence of not only one but usually several of the following criteria. Conversely, minor conjunctivitis does not present these findings.

Findings in a Red Eye Suggesting Major Disease

(1) **Vision.** Definite reduction in acuity occurring since the onset of redness should *always* be regarded with great suspicion.

(2) **Pain.** Severe discomfort strongly suggests corneal damage or serious intraocular or orbital involvement. Although painful corneal abrasions usually heal without trouble, they represent a potential portal of entry for infection and cannot be disregarded.

(3) **Opacities.** Fresh corneal infiltrations or debris within the normally transparent eye structures are always serious. Bright, obliquely directed, moving illumination as from a small flashlight is best for observation of anteriorly situated opacities. Opacities posteriorly situated in lens or vitreous are best appreciated as dark shadows against the ophthalmoscopic red reflex.

(4) **Pupil.** Irregularities in size and shape of the pupil result from intraocular inflammation or trauma. A smaller pupil on the side of a red eye is an excellent indicator of iritis, whereas an enlarged pupil suggests acute glaucoma (unless due to mydriatic therapy).

(5) **Distribution of Redness.** A red halo immediately encircling the cornea (limbal flush) almost invariably indicates serious eye disease. Redness diffusely distributed throughout the conjunctival area may occur with either benign or serious causes of red eye and has no diagnostic significance.

(6) **Pressure.** Noticeable alterations in pressure of the red eye, either hard or soft, as determined by finger tension estimation, indicates serious disease.

(7) **History.** Redness in an eye known previously to have suffered from serious disease such as uveitis or glaucoma must be regarded as a recurrence until proven otherwise. Presence of bacterial conjunctivitis in other members of the family suggests the diagnosis of this simple, benign infection.

(8) **Response to Therapy.** Should diagnosis of a minor cause of red eye have been made, failure to respond to adequate therapy within two or three days should cast doubt upon the accuracy of diagnosis.

If, by means of these eight signals of major disease, a red eye is determined to have a serious etiology, the cause should be diagnosed and receive specific treatment. Should the physician be unable to arrive at a diagnosis, urgent ophthalmologic consultation is in order.

The Author

● **Dr. Havener, Columbus, is on the attending staff at University Hospital, and Acting Chairman, Department of Ophthalmology, The Ohio State University College of Medicine.**

MATERNAL HEALTH IN OHIO

TOPIC THIS MONTH:

Maternal Deaths* Involving Pulmonary Embolism

WITH this issue of *The Journal,* the "Maternal Health in Ohio" column enters its third consecutive year of publication. The Committee on Maternal Health acknowledges with gratitude the wholehearted cooperation of Ohio physicians, county chairmen, and many others, without whose untiring efforts and assistance this study could not be maintained.

Case No. 174

This 31 year old white, gravida IV, Para III, died 13 hours postpartum. She had had an appendectomy some years ago without sequelae. The patient had had no complications with her previous three pregnancies and her prenatal course with her final pregnancy was uneventful. Last menstrual period was October 10. At 37 weeks she was admitted to the hospital in active labor, at which time the physical examination was normal. Labor progressed satisfactorily (duration was given as 15 hours) and she delivered spontaneously with an ether anesthetic administered by a nurse. The placenta followed three minutes after delivery of the infant and disclosed absence of multiple cotyledons. The baby weighed 2381 grams; both mother and infant appeared perfectly well. *Thirteen hours* after delivery the mother suddenly began to gasp for air while engaged in a telephone conversation. The nurse was unable to obtain a pulse or heart beat; respirations ceased and she was pronounced dead 10 minutes later. Autopsy permission was obtained.

Pathological Diagnosis: Bilateral, massive pulmonary embolism; partial retained placenta. (The placental fragment was 3 cm. in thickness and was located in the left cornu of the uterus. Sections through the broad ligament failed to disclose evidence as to the origin of the embolic material.)

Comment

The Committee voted this a nonpreventable maternal death. The speed with which fatal sequelae occurred, obviously made intervention hopeless. The record reveals no exploration of the uterine cavity following discovery of the missing chunk of placenta; available information does not indicate that its removal would have changed the fetal course of the tragedy.

Case No. 187

This 34 year old white, Primigravida expired 16 days postpartum. The past medical history of this *obese* patient was not significant. She was first seen by her physician in the fourth month of gestation. Her height was five feet and she weighed 230 pounds. The original blood pressure was 130/80 and urine was negative for albuminuria. Last menstrual period was September 6; prenatal care was considered adequate. At 34 weeks gestation she was hospitalized because of hypertension (highest was 180/120), albuminuria and edema and was discharged after the toxemia was controlled. Therapy included low salt diet, Diamox®, Thiomerin® and bed rest. She was re-hospitalized at 40 plus weeks for treatment of her pre-eclampsia, at which time she weighed 272 pounds. X-ray pelvimetry did not reveal any disproportion.

On the fifth day of this hospitalization labor began spontaneously (3 weeks past term). She delivered a 10 pound, 11 ounce stillborn baby after a 24 hour labor. Delivery was accomplished with low forceps and episiotomy; anesthesia (type not reported) administered by a registered nurse. The third stage was reported normal. After delivery her blood pressure and urinary findings returned to normal and she was discharged on her sixth postpartum day. Details of laboratory studies were not recorded. Before discharge the blood pressure was 140/84.

At home the patient developed chills, fever and left chest pain on the tenth postpartum day and was readmitted to the medical service of the same hospital. Temperature was 100, moist rales were present in the left lower chest. There was tenderness in the left lower quadrant of her abdomen and there was 3 plus pedal edema bilaterally. Her symptoms improved on therapy consisting of rest, sedation and antibiotics. An x-ray on the 14th postpartum day showed consolidation in the left lower lobe interpreted as an *atypical pneumonia.* On her 16th postpartum day she became nauseated, apprehensive, cold, clammy and complained of severe abdominal pains. Her vital signs became unobtainable and she expired July 30. Autopsy permission was granted.

Pathological Diagnosis: Bilateral pulmonary infarcts, thrombosed pelvic veins and endometritis.

Comment

The Committee voted this case a nonpreventable maternal death. However, several items of interest were raised by members; it would have been

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*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by official representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

helpful to know reports of laboratory studies performed on the patient's blood. Second, when did attendants learn of fetal death? In view of the fact her estimated date for term was June 13, it would seem that induction of labor should have been considered prior to her final hospital admission July 25th.

Case No. 248

This 25 year old white gravida III, Para II died undelivered in the third month of gestation. There was no information on the past surgical or medical history. No data available on previous pregnancies. Last menstrual period was in November (?). The patient was known to have been involved in an automobile accident in a southern state in the third month of her pregnancy but information concerning the extent of injuries could not be obtained.

On February 23, (about one month after coming to Ohio) she noticed chest pain and abdominal distention and consulted a physician. She was given a cursory examination, at which time the pregnancy was confirmed, blood pressure was 100/80 and temperature was 99.8. The patient was given a placebo for "gas" and advised to contact the physician in 24 hours if no improvement was noted; this she did but the physician was not in at the time of the call. That night (Feb. 24) the patient suddenly collapsed and died in the living room of her home. She was not seen by the physician until after her death. Autopsy was performed.

Pathological Diagnosis: At autopsy there was present a dilated right heart; lungs showed massive bilateral pulmonary artery thrombosis and thrombi were noted in the broad ligament vessels. With the opening of the uterus it was noted that there was a 3 inch area of *placental separation* with some blood in the uterus. The fetus measured 20 cm. in overall length.

Comment

The Committee studied this case with a great deal of interest. Certain details omitted from the past history (i.e., a 4-inch scar over the left lower quadrant) might have helped to explain the background of the fatal processes. The insidious character of aseptic pelvic thrombosis is apparent from the report of this case. Obviously, the role of the trauma of the automobile accident as a contributing cause to the formation of the thrombi is a matter for speculation. The Committee voted this a nonpreventable maternal death.

Comment of Consultant

The following comment of a consultant, a specialist in thoracic surgery, was given at the request of the Committee.

The only common denominator in the three patients presented is that all three died of pulmonary embolus, found to be massive at autopsy. In **Case No. 174** the patient died 13 hours following a fairly normal though prolonged labor without evidence of previous pelvic infection or other contributory factors. This certainly is not the usual picture of pulmonary embolus. It would be extremely interesting to know whether the embolus was sectioned and possibly might have been placental tissue which entered the pelvic veins during this somewhat prolonged labor for a Para III. Since this embolization was totally unexpected and occurred while the patient apparently was ambulatory and occurred with such suddenness, any medical or surgical therapy even in the most ideal environment could not have been applied.

In the other two patients (**Case No. 187** and **Case No. 248**) there is definite evidence of previous pelvic infection. The record, however, is incomplete in that adequate data are not available indicating the duration and extent of such infection. Patients with symptoms and findings of pelvic sepsis should have a thorough investigation and specific antibiotic therapy and heparinization should be instituted. Statistics of carefully evaluated series are now available indicating that control of sepsis and the proper use of heparin will reduce the incidence of fatal pulmonary emboli.

Most pulmonary emboli occur in the fourth to the tenth day postoperative and post-delivery period of time and are not always massive in nature. Multiple smaller emboli may be the prodromal signs of disaster; however, the use of heparin in this period of time although not dissolving already present emboli will prevent the formation of arterial thrombi and will prevent the progression of pulmonary embolization which will lead to obstruction of the pulmonary arterial flow, hypertension, and eventual right heart failure.

A good discussion of the problems of pulmonary embolization was presented by the consultant on pages 1058 and 1059 of the August, 1958, issue of this journal.

Cautious Use of Steroids Advised

In the asthmatic child, corticotropin or corticoid hormones may be employed to arrest the symptomatic crisis. The physiologic activity of the hormones is used in a rational way, though less frequently, in dermatologic forms of allergy such as urticaria and angioneurotic edema. It has been established that corticotropin or ACTH tends to induce adrenal hyperplasia with glandular hyperfunction. Corticosteroids, however, may produce changes in the structure of the gland which may lead to atrophy of the cortex with subsequent hypofunction. A cautious use of steroids is advised. Repeated short courses are preferred and daily or continued routine administration of these preparations is thought to be ill-advised.

Overfamiliarity with these products may lead one to forget their tremendous potentiality and this is especially true in pediatric practice.—G. Estrada de la Riva, M. D., Havana: *South. M. J.*, 51:865, July, 1958.

A Clinicopathological Conference

Edited Under the Auspices of the Ohio Society of Pathologists

WILLIAM SINCLAIR, M. D., ***President***

Presentation of Case

THIRTY-SIX HOURS prior to admission to the University Hospital, Columbus, Ohio, this 67 year old white man developed generalized pain over the lower abdomen which was more intense in the right lower quadrant but did not radiate to the back, legs or umbilicus. The pain was described as a constant dull ache. A few hours after the pain started he became nauseated and vomited thick brown fluid without food particles. He vomited approximately eight times in 24 hours, about a cupful each time. He had had a meal 30 minutes before the pain started. He gave no history of previous abdominal pain. He had noted constipation two days prior to the onset of the pain.

The patient had been in good health until five years ago. He had had an asymptomatic umbilical hernia for years and had had hypertension for the past five years with blood pressure of about 170 over 110. He had had no blood transfusions or operations. For 30 years up until two years ago he drank 15 bottles of beer a day, since then five bottles a day. For the past five to six years he had noted vertigo and had been "hard of hearing."

Review of the cardiorespiratory system revealed some exertional dyspnea with asthma for 10 years and hypertension for five years; he had never had edema of his legs, or chest pain. Gastrointestinal history revealed poor appetite and constipation requiring cathartics for the last two months; he suffered a 10 pound weight loss during the last two to three weeks and had fatty food intolerance and mild intermittent jaundice for the past year. He had nocturia of three to four times.

Presented by

- **Daniel W. Elliott, M. D., Columbus, and**
- **Emmerich von Haam, M. D., Columbus.**

Edited by Dr. von Haam.

Physical Examination

Temperature 99.4°F., respirations 24, pulse 80, blood pressure 90 over 40. He was a pale, obese white man who appeared chronically ill and in acute distress due to abdominal pain. His skin was dry and scaly, his lymph nodes were not enlarged or tender. His chest was increased in the posterior-anterior diameter, hyperresonant on percussion, with decreased breath sounds. Numerous coarse rhonchi with occasional fine rales could be heard over both bases. His heart was not remarkable.

The abdomen was distended and tympanitic; bowel sounds were absent. There was marked direct and rebound tenderness over the entire abdomen which was more marked in the right upper and lower quadrants. He had a 3 cm. umbilical hernia. A firm, irregular mass 5 to 6 cm. in diameter was palpable in the right upper quadrant. Due to tenderness it was not possible to decide whether this mass moved during respirations. The abdominal veins were not dilated.

Rectal examination revealed an enlarged prostate and tarry stool which was guaiac-positive. He showed no edema of his extremities, and his femoral pulses were equal. The neurological examination was not remarkable. On paracentesis no fluid was obtained from the right lower quadrant; from the left lower quadrant 6 cc. of turbid yellow fluid was obtained.

Laboratory Findings

Red blood count 4.32 million, hemoglobin 11.8 Gm.; white blood count 10,600 with 68 per cent nonsegmented neutrophils, 19 per cent segmented, 9 per cent lymphocytes, 4 per cent monocytes. Urinalysis: specific gravity 1.026; *p*H 4.5; protein 10 mg.; some coarse granular and rare fine granular casts; 2 to 3 white and red blood cells per high power field, bacteria 3 plus. His serum amylase was 962 units; his prothrombin time 52.6 per cent; the blood urea nitrogen 33 mg. and the blood sugar 115 mg.

His serum sodium was 126 mEq., potassium 4.1 mEq. and chlorides 93 mEq. His total serum proteins were 5.5 Gm. with 3.1 Gm. of albumin and 2.4 of globulin. His icterus index was 3; the thymol turbidity and the cephalin flocculation were negative. The inorganic serum phosphorus was 2.9 mg., his alkaline phosphatase 4.2 units. The bromsulphalein test showed 24 per cent retention. Electrocardiogram showed a nodal rhythm with A-V dissociation or fibrillation.

Roentgenographic Findings

The chest film showed enlargement of the heart, an elongated and tortuous aorta, congested lung fields (the right greater than the left), and a small right pleural effusion. Anteroposterior and lateral films of the abdomen showed small amounts of gas outlining the colon and duodenum, and a long fluid level along the right colon, suggestive of free peritoneal fluid.

Hospital Course

On the second hospital day his blood pressure dropped to 80, the pulse was 88 and temperature rose to 102°F. Three paracenteses were attempted but no fluid was obtained. The next day he was more alert, his abdomen was softer but tender; peristalsis was still absent. He was noted to have expiratory wheezes and cough. The serum amylase dropped to 229 units; his blood urea nitrogen was 31 mg. His white blood count rose to 15,600. On the third hospital day his abdomen was tender but soft and peristalsis was beginning to appear. His temperature was 104 F., and his blood pressure 164 over 80. He was placed on Chloromycetin® and tetracycline.

On the fourth hospital day his temperature was still elevated. Paracentesis was attempted twice and again no fluid was obtained. On x-ray the degree of ileus seemed increased since the previous film. His serum amylase was 89 units. The following day many rales were present in both bases posteriorly. Bowel sounds were present; he passed a dark liquid strongly positive for blood on guaiac test. He developed thrombophlebitis of the right leg extending to the groin. On the fifth hospital day tracheotomy was performed. On the sixth day he seemed slightly improved and took some fluids by mouth. The thrombophlebitis was responding and there was a decrease of his edema. His temperature was 104°F. He received a whole blood transfusion.

On the seventh hospital day the chest seemed somewhat cleared, the abdomen less tender with good bowel sounds and no distention. Fluids were limited to 1000 cc. Temperature was 103-104°F. Suddenly he vomited thick greenish fluid. He was suctioned through the tracheotomy wound without return. His respirations and his heart beat stopped and he was pronounced dead at 10:50 a. m. of his seventh hospital day.

Clinical Discussion

Dr. Elliott: This elderly man was apparently brought to the hospital 36 hours after sudden onset of pain, and we would think of this as sudden because the man had eaten only 30 minutes before, so he must not have felt even vague symptoms of warning. The pain was diffuse across the abdomen, which is suggestive of a diffuse process irritating the peritoneum. He vomited almost immediately and his vomiting was of a type which may be found in intestinal obstruction, ileus, or any severe abdominal pain. Vomiting of brown fluid suggests that there may have been blood or feces in the vomitus. The fact that constipation had been present for two days before his sickness suggests the possibility of some obstruction underlying the abdominal process, but not necessarily so.

Looking for a background for his acute episode, we find several statements in the story to make it a little confusing. His asymptomatic umbilical hernia may well have been responsible for his acute episode. However, hernias almost invariably show some local symptoms if significant incarceration occurs. The past history of hypertension makes us think of arteriosclerosis with mesenteric thrombosis and the past history of alcoholism is also worthy of comment. Fifteen bottles of beer a day is a lot of beer, particularly when it is drunk habitually, and its alcohol content is about equivalent to two thirds of a fifth of whisky.

Vertigo

The fact that he had cut down on his beer lately suggests that he was not feeling as well as usual and that he had begun to have some type of abdominal symptoms as early as two years ago. The vertigo seems not related in any way that I know to the abdominal disease but is more suggestive of a chronic process like otosclerosis. The absence of chest pain suggests that his pain originated definitely in his abdomen and speaks against any myocardial disease which might be accompanied by mesenteric embolism. The story of a 10-pound weight loss suggests that there was some type of chronic disease in his recent past. The fatty food intolerance of no specified duration also points to some intra-abdominal disease, either two years ago when he cut down on his beer or a month or two ago when his weight began to decline. His recent constipation might be due either to an obstructive lesion such as diverticulitis or carcinoma, or it might be due to decreased food intake.

The mentioning of an intermittent jaundice seems extremely important in the evaluation of the patient's chronic disease background. It is important to know whether he really had jaundice. We gather that this jaundice was painless and was not accompanied by itching. The patient did not have jaundice when in the hospital because his laboratory findings were all negative, but we must consider all circumstances which will produce painless intermittent jaundice. Certainly any hemolytic process could do it, but then we would expect some degree of anemia, which he did not have. We might suspect liver cirrhosis on the basis of his alcoholism and also suspect gallbladder disease, since we know that jaundice due to common duct stones can frequently be painless and may last only 24 to 48 hours. I believe that his jaundice was probably due to cirrhosis of his liver or some obstructive lesion.

When the patient looked for medical aid 36 hours after onset of his illness he already was in a severe state of shock. We know that he had had hypertension in the past and for this reason his blood pressure obtained in the emergency room indicated severe shock. Any acute abdominal emergency that produces shock in the course of 36 hours is a severe one. The fact that his pulse rate was not much increased may indicate some degree of myocardial limitation. We know that a good many older people when they lapse into shock cannot greatly increase their pulse rate because of chronic myocardial insufficiency.

Dehydration

He also was dehydrated, which would not be surprising with fluid pouring into his abdomen, his vomiting of fluid and his loss of electrolytes. His chest findings suggest emphysema with either bilateral basal pneumonia or pulmonary atelectasis due to elevated diaphragm. In any patient with 36 hours of acute abdominal pain, I would be inclined to explain the rales in both bases as compression atelectasis due to elevated diaphragm.

His generalized direct and rebound abdominal tenderness certainly suggests severe diffuse peritoneal irritation. The tenderness and the rigidity of his abdomen apparently prevented an accurate evaluation of the mass palpable in the right upper quadrant. Since it was irregular, I assume that it was not liver which the observer was feeling. The presence of guaiac-positive stools in his rectum would lead us to believe that he had a lesion within the gastrointestinal tract except for the fact that gastrointestinal bleeding occurs often in many shock-producing diseases.

I certainly agree that his was the type of abdomen in which paracentesis should be employed. The fact that fluid was obtained at all indicated an abnormal process occurring in the abdomen. Despite his dehydration his hemoglobin was not much elevated, and his white blood cell count indicated that he was acutely ill, while his urine analysis suggested a pretty normal renal function.

The test for serum amylase showed values clearly elevated beyond the range of any casual interference with normal amylase. So the question arises: What elevates amylase? The most important condition is of course pancreatitis. It elevates serum amylase within an hour or two after onset and at the end of four hours the level should reach its peak and start to drop. Rupture of the small bowels, perforation of a stomach ulcer and diseases of salivary glands, like mumps, will also elevate amylase but usually not that much. The reduced prothrombin suggests some degree of liver impairment. Although prothrombin will be less during starvation, it should not be reduced after only 36 hours of illness.

His blood urea nitrogen excludes primary kidney disease, and the blood sugar certainly rules out diabetes. His 24 per cent retention of bromsulphalein does not necessarily mean cirrhosis of the liver when it is obtained while the patient is in shock. The other battery of liver tests does not appear remarkable and certainly does not allow us to suspect any jaundice or obstruction of the biliary tree.

Summary

In summary then, all we know about this man is that he had a process going on which produced a lot of peritoneal irritation and paralytic ileus. X-ray examination confirmed these findings. He also was in shock. One most certainly would be reluctant to subject this man to surgery. Therefore we must rule out conditions for which surgery is mandatory. We do not have sufficient evidence to point to a dead or perforated viscus, which would require immediate surgical intervention. Therefore a tube was put in the stomach, his intestines were decompressed, and appropriate fluids were administered to get him out of shock.

He improved transitorily but lapsed again into shock with very low sodium levels. That suggests to me that he was given too much water and not enough saline in the course of his first management, and after he was treated with appropriate electrolytes he responded again and his abdomen seemed improved. His serum electrolytes became normal but he developed pitting edema and signs of bronchopneumonia.

As for his gastrointestinal tract bleeding, evidenced by the guaiac-positive stools, we know that 16 to 20 per cent of patients with pancreatitis show such bleeding for reasons that I do not definitely understand. We also know that 10 per cent of our patients with pancreatitis have acute cholecystitis. So we would not be surprised if the mass in his right upper quadrant would be an enlarged gallbladder, but we would operate only when we suspected it was about to rupture or had already ruptured. The fact that this mass was first palpable and later disappeared would lead us to wonder if the gallbladder was actually distended, acutely inflamed and later perforated, and one certainly would watch his abdomen closely for signs of bile peritonitis and tap him again when previous paracenteses were negative.

I think I accept the diagnosis of pancreatitis.

Since his abdomen improved, I feel certain that he did not have a condition for which we would need to operate. The principal reason to suspect pancreatitis was the fact that this man's serum amylase ran such a typical course. It became high within 36 hours after onset of his trouble and fell over the next 48 hours. This is about average time for amylase to drop, although the pancreas may well proceed to suppuration and pseudocyst formation. I therefore agree that the patient had pancreatitis.

The physical findings in his right upper quadrant suggest that he may have had chronic cholecystitis with gallstones. We know that two thirds of our patients with acute pancreatitis as their chief symptom will have gallstones, another 10 per cent will be alcoholics. In the remaining patients we cannot explain why pancreatitis should have occurred. I suppose that this man died of bronchopneumonia and congestive failure, and that we will find a hemorrhagic pancreatitis and a cholecystitis and possibly, but not necessarily, lesions of his gastrointestinal tract accounting for his bleeding.

General Clinical Discussion

Dr. von Haam: Almost every student made the diagnosis of pancreatitis, but two thirds also felt that a malignant tumor was present which might have been either a carcinoma of the colon, pancreas, the liver or the gallbladder. Dr. Elliott, do you think that the patient had an occult malignant tumor?

Dr. Elliott: I don't think we have enough evidence to suspect an occult tumor in this patient. I think that if we had nursed him over his acute attack of pancreatitis and got him feeling better, then a diligent search should have been undertaken to exclude cholecystitis, peptic ulcer or an occult tumor.

Clinical Diagnosis

1. Acute pancreatitis with fat necrosis and peritonitis.
2. Chronic cholecystitis.
3. Alcoholic cirrhosis of the liver.
4. Bilateral bronchopneumonia.
5. Chronic pulmonary emphysema.

Pathologic Diagnosis

1. Acute pancreatitis with abscess formation, fat necrosis and acute peritonitis.
2. Chronic pancreatitis.
3. Chronic cholecystitis and cholelithiasis.
4. Severe parenchymatous and fatty degeneration of the liver.
5. Chronic pulmonary emphysema.

Pathologic Discussion

Dr. von Haam: The patient was normally developed and moderately obese. The upper portion of the peritoneal cavity was sealed off by dense fibrous adhesions involving the omentum, the mesentery, the stomach, liver and pancreas. The peritoneum of this region was studded with multiple yellow plaques and covered with yellow fibrinous exudate. The pleural cavities contained 1300 cc. of dark amber fluid. The heart was enlarged but otherwise normal. The lungs appeared heavy and showed chronic emphysema of the upper lobes and congestion with atelectasis of the lower lobes. Both lungs were edematous and the small bronchi contained thick yellow exudate.

The liver was light tan and smooth. The gallbladder was thickened and contained mucoid bile and 20 mixed gallstones. The pancreas appeared swollen and was studded throughout with numerous yellow necrotic plaques. An abscess filled with greenish yellow pus was found in the region of the head of the pancreas. No bleeding points were discovered in the gastrointestinal tract, which appeared normal. The kidneys were swollen and finely granular. The remaining gross findings were not remarkable.

Microscopic Examination

Sections through the heart showed a severe and significant interstitial edema. The lungs showed chronic emphysema and severe edema. Sections through the liver showed severe fatty changes with slight increase in the thickness of the periportal spaces and some inflammatory cells in these areas. Sections of the gallbladder showed a rather severe chronic inflammatory process. Section of the pancreas showed typical changes of chronic interstitial pancreatitis in addition to acute changes of pancreatic fat necrosis. There were no hemorrhages or vascular changes and the areas of fat necrosis were not severely inflamed. Section of the kidney showed severe tubular degeneration and moderate arteriolar nephrosclerosis. The brain showed many small subependymal hemorrhages in the third and fourth ventricles.

In summary, the patient had most of the conditions which Dr. Elliott predicted. He had acute pancreatitis superimposed upon chronic pancreatic disease. He had cholecystitis with gallstones and a liver damaged by alcoholism. The fatal lesions at autopsy were the severe myocardial edema and his cerebral hemorrhages, both of which were probably caused by action of the circulating pancreatic enzymes with capillary damage. Overhydration also may have played some part in the accumulation of his hydrothorax. While the diagnosis in this case did not seem difficult, the management apparently was.

The Achievements of Arist

...in Skin Diseases: In a study of 26 patients with severe dermatoses, ARISTOCORT was proved to have potent anti-inflammatory and antipruritic properties, even at a dosage only ⅔ that of prednisone[1]... Striking affinity for skin and tremendous potency in controlling skin disease, including 50 cases of psoriasis, of which over 60% were reported as *markedly improved*[2]...absence of serious side effects specifically noted.[1, 2, 3]

...in Rheumatoid Arthritis: Impressive therapeutic effect in most cases of a group of 89 patients[4]... 6 mg. of ARISTOCORT corresponded in effect to 10 mg. of prednisone daily (in addition, gastric ulcer which developed during prednisone therapy in 2 cases disappeared during ARISTOCORT therapy).[5]

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12. Cooke, R. A.: Personal Communication.
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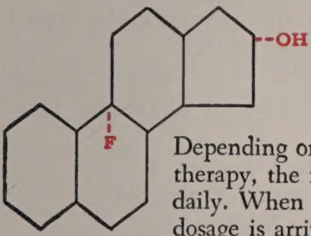
...in Respiratory Allergies: "Good to excellent" results in 29 of 30 patients with chronic intractable bronchial asthma at an average daily dosage of only 7 mg.[6]... Average dosage of 6 mg. daily to control asthma and 2 to 6 mg. to control allergic rhinitis in a group of 42 patients, with an actual reduction of blood pressure in 12 of these.[7]

...in Other Conditions: Two failures, 4 partial remissions and 8 cases with complete disappearance of abnormal chemical findings lead to characterization of ARISTOCORT as possibly the most desirable steroid to date in treatment of the nephrotic syndrome.[8,9]... Prompt decrease in the cyanosis and dyspnea of pulmonary emphysema and fibrosis, with marked improvement in patients refractory to prednisone.[10,11,12]... Favorable response reported for 25 of 28 cases of disseminated lupus erythematosus.[13]



Depending on the acuteness and severity of the disease under therapy, the initial dosage of ARISTOCORT is usually from 8 to 20 mg. daily. When acute manifestations have subsided, maintenance dosage is arrived at gradually, usually by reducing the total daily dosage 2 mg. every 3 days until the smallest dosage has been reached which will suppress symptoms.

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ARISTOCORT is available in 2 mg. scored tablets (pink), bottles of 30; and 4 mg. scored tablets (white), bottles of 30 and 100.

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Fall Postgraduate Courses . . .

District Organizations and Other Groups Arrange Interesting Programs; Excellent Postgraduate Material Within Easy Reach of Most Physicians

AGAIN this fall physicians of Ohio will have an opportunity to attend excellent postgraduate courses, several of them sponsored by district organizations. Many of the programs are annual events and are well known to physicians. Others have been designed to fulfill particular needs as refresher courses.

Scientific and clinical discussions are the core of these meetings, but no small part of the events are the banquets and other occasions for physicians to get together informally with their colleagues.

Additional information on these and other programs will be published in subsequent issues of *The Journal*. Following are the programs announced before this issue went to press:

September 19—Industrial Medical Association of Pittsburgh, Program on Industrial Medicine, Akron.

October 1 - 2—Ohio Academy of General Practice Annual Scientific Assembly, Toledo.

October 2—Eighth District Medical Meeting, Zanesville.

October 3—Montgomery County Medical Society Annual Founders' Day, Dayton.

October 17—Mississippi Valley Trudeau Society Annual Meeting, Dayton.

October 19—Third Annual Session on Rheumatic Diseases, Ohio State University, Columbus.

October 22—Sixth District Postgraduate Day, Akron.

November 1—Columbus Academy of Medicine, Clinic Day, Columbus.

Series of Postgraduate Courses—Bunts Educational Institute, Cleveland.

* * *

Industrial Medical Program To Be Conducted in Akron, Sept. 19

The Industrial Medical Association of Pittsburgh, a component society of The Industrial Medical Association, will present a program on Friday, September 19 at the Sheraton Hotel, in Akron.

9:00 A. M.—Registration—*Promptor Finis Fui.*

9:30—Greetings by Dr. Arthur Dobkin, president of the Summit County Medical Society. Remarks by Dr. Don A. Kelly, Cleveland, president of the Industrial Medical Association of Pittsburgh.

9:45—**The Use of the Artificial Kidney in Poison Cases**, Dr. Walter A. Keitzer, Akron.

10:15—**Lung Surgery as Related to Occupational Conditions**, Dr. William H. Falor, Akron.

10:45—Recess.

11:00—**Reconstructive Surgery in Industry**, Dr. E. J. Kraker, Akron.

11:30—**Rehabilitation of Industrial Workers**, Dr. K. C. Keeler, Akron.

12:00 M—Luncheon and showing of the film, "Medicine in the Tropics."

1:30 P. M.—**Panel**, Moderator, Dr. Paul A. Davis, Akron.

1. **Health Hazards in the Rubber Industry, Yesterday and Today**, Dr. Warren L. Hogue, Jr., Akron.
2. **Toxicology of Materials Used in the Rubber Industry**, Dr. Rex H. Wilson, Akron.
3. **Relationship of Industrial and Private Practice**, Dr. L. C. Hatch, Akron.

3:40—Business Meeting.

4:00—Cocktail Party.

* * *

Ohio Academy of General Practice To Meet in Toledo, Oct. 1 -2

The Ohio Academy of General Practice has announced its Eighth Annual Scientific Assembly to be held in Toledo, Wednesday and Thursday, October 1 and 2. Scientific programs and the exhibit will be in the Civic Auditorium and the banquet will be in the Commodore Perry Hotel.

The OAGP House of Delegates will convene on Tuesday, September 30, at 9:30 a. m. in the Crystal Room, Commodore Perry Hotel.

The program is acceptable for 13 hours Category I Credit for American Academy of General Practice members.

Wednesday, October 1

(All time is Eastern Standard)

8:00 Registration and Visit Exhibits

8:45 Opening Annual Scientific Assembly

9:00 **Therapeutically Induced Weight Gains in Hypertensives** — Dr. Harold S. Feldman, Livingston, N. J.

9:45 **Pre-Menstrual Tension — Psychogenic Dysmenorrhea**—Dr. Eduard Eichner, Cleveland

10:30 Visit Exhibits

11:15 **Diseases Caused by Viruses**—Dr. C. N. Christensen, Indianapolis, Indiana

12:00 Lunch and Visit Exhibits

1:30 **Office Management of Diabetes**—Dr. Geo. J. Hamwi, Columbus

(Continued on Next Page)

(Ohio Academy of GP — Continued)

2:15 **Endocrines in the Handling of Pregnancy**—Dr. Robert B. Greenblatt, Augusta, Georgia
3:00 Visit Exhibits
3:45 **The Emerging Awareness of Radiation Hazards**—Dr. William G. Myers, Columbus
4:30 Visit Exhibits
6:30 Social Hour and Banquet (Ball Room, Commodore Perry Hotel — Entertainment and Dancing.)

Thursday, October 2

8:00 Registration and Visit Exhibits
9:00 **Current Concepts in the Treatment of Congestive Heart Failure**—Dr. John Messina, Cleveland
9:45 **Surgical Emergencies in the Newborn**—Dr. Alan D. Shafer, Dayton
10:30 Visit Exhibits
11:15 **Trends in Pediatric, Adult and Geriatric Nutrition**—Dr. Julius Pomeranze, New York City
12:00 Lunch and Visit Exhibits
1:30 **Space Medicine**—Dr. Fred A. Hitchcock, (Ph. D.), Columbus
2:15 **Keeping the Arthritic Patient Going**—Dr. Edwin W. Passarelli, Chicago
3:00 Visit Exhibits
3:45 **Preparation for Marriage and Parenthood**—Dr. Milton Abramson, St. Paul, Minn.
4:30 Visit Exhibits
5:30 Adjournment

* * *

Eighth Councilor District Program In Zanesville, October 2

The Eighth District Medical Meeting will be held at the Zanesville Country Club, Thursday, October 2.

Morning golf will be available for those who wish to play.

From 2:00 to 4:00 in the afternoon a symposium on neurological diseases will be held with the following speakers from the University of Buffalo:

Dr. W. B. Hamby, professor of neurosurgery;

Dr. Bertram Bean, assistant professor of radiology; and

Dr. Bernard Smith, professor of neurology.

The ladies will be entertained with an afternoon tea. Registrants and the ladies may attend evening dinner featuring an entertaining speaker.

All physicians in the Eighth District will receive registration forms. Other physicians are invited to attend and may register by writing to Earl R. Haynes, M. D., Secretary, Eighth District, 838 Market Street, Zanesville, Ohio.

Montgomery County Society Founders' Day Program Scheduled Oct. 3

The Montgomery County Medical Society's annual Founders' Day meeting is scheduled at the Biltmore Hotel in Dayton, Friday, October 3. This event will mark the 109th anniversary of the organization.

All physicians of the Second Councilor District are being invited to attend this program.

The program will be in the form of a symposium on cancer chemotherapy.

The afternoon program will feature a workshop on chemotherapy. The evening program will consist of a panel discussion on the subject of the clinical application of chemotherapy. As is customary a social hour and dinner will be main attractions of the day's events.

The panel of some of the nation's leading authorities on cancer chemotherapy will include the following:

Dr. Kenneth M. Endicott, director of the National Institute of Health Cancer Division; and

Dr. Byron E. Hall, Stanford University Medical School, and director of the Western Cooperative Chemotherapy Study.

* * *

Mississippi Valley Trudeau Society Scheduled in Dayton, Oct. 17

The Annual meeting of the Mississippi Valley Conference on Tuberculosis and the Mississippi Valley Trudeau Society are to be held at the Biltmore Hotel, Dayton, October 16-18. The Trudeau Society meetings will be on Friday, October 17.

The program of the Trudeau Society has been announced as follows:

Morning Session

Presiding: Dr. William M. Spear, Vice-President, MVTS, Oakdale, Iowa.

9:30 **Chemotherapy of Tuberculosis, An USPHS Cooperative Study**, (Speaker to be announced.)
9:45 **The Present Significance of the Biological Inactivation of Isoniazid in the Chemotherapy of Tuberculosis**, Dr. J. Park Biehl, Christ Hospital Institute of Medical Research, Cincinnati.
10:05 **The Detection of Curable Lung Cancer**, Dr. Katherine R. Boucot, professor of preventive medicine, Woman's Medical College of Pennsylvania, Philadelphia.
10:45 **Eosinophilic Infiltrations in Lung**, Dr. Matthew B. Divertie, Mayo Clinic, Rochester, Minn.
11:05 Panel Discussion: **Atypical (Anonymous) Mycobacteria**, Moderator, Dr.

(Continued on Next Page)

(Trudeau Society — Continued)

Dieter Koch-Weser, Western Reserve University. Participants, Dr. Wendell H. Hall, chief of laboratory services, Veterans Administration Hospital, Minneapolis, Minn; Dr. Emanuel Wolinsky, Western Reserve University, Cleveland; and Dr. Lawrence E. Wood, Kansas City, Missouri.

Luncheon

Afternoon Session

Presiding: Dr. Harold G. Curtis, President, MVTS.

2:00 **An Analysis of Various Surgical Procedures for Primary Pulmonary Neoplasms,** Herbert C. Maier, director of surgery, Lenox Hill Hospital and associate clinical professor of surgery, Columbia University, New York.

2:45 **Interstitial Pulmonary Fibrosis,** Dr. Howard S. Van Ordstrand, and Dr. W. Robert Biddlestone, Department of Pulmonary Diseases, Cleveland Clinic.

3:05 **Needle Biopsy of the Parietal Pleura,** Dr. George S. Schools, Department of Internal Medicine, University of Michigan Medical School, Ann Arbor.

3:25 Panel Discussion: **Inoperable Pulmonary Neoplasm.** Moderator, Dr. Virgil A. Plessinger, Cincinnati. Participants, Dr. Charles M. Barrett, professor of radiology-radiotherapy, University of Cincinnati; Dr. Maier and a third speaker to be announced.

4:30 **Bronchoscopy in the Diagnosis of Intrathoracic Disease,** Dr. Paul H. Holinger, Chicago.

5:00 Business Meeting.

* * *

Sixth District Postgraduate Day In Akron, October 22

An annual event that has become a leading scientific program in its area is the Sixth Councilor District Postgraduate Day, scheduled this year at the Sheraton-Mayflower Hotel, Akron, on Wednesday, October 22. This event drew well over 500 physicians last year, a large number of counties outside of the Sixth District.

A letter of instructions is scheduled to go to physicians within the District early in September informing them of the program and giving directions for advance registration.

Physicians who register in advance will have a choice of having luncheon with any one of the speakers where a free discussion in the form of questions and answers will be held. The general luncheon will be held at the Sheraton-Mayflower with the Obstetrics-Gynecology section luncheon at the Akron City Club.

The program is an all day event with registration beginning at 8:00 a. m. Section meetings will run concurrently so that each physician will have a choice of the program he wishes to attend.

The banquet will be a feature of the program. An outstanding speaker will discuss the general theme of medical matters allied with community responsibility.

This year 24 commercial exhibits have reserved space at the meeting place, emphasizing an increasing interest on the part of exhibitors.

The program had not been completed at the time this issue went to press, but speakers in two sections were confirmed.

Obstetrics and Gynecology

Speakers for the Section on Obstetrics and Gynecology will include:

Dr. Allen F. Guttmacher, chairman, Department of Obstetrics and Gynecology, Mt. Sinai Hospital, New York City.

Dr. M. Edward Davis, chairman, Department of Obstetrics and Gynecology, University of Chicago and the Chicago Lying-In Hospital.

Dr. Frederic Zuspan, assistant professor of obstetrics and gynecology, Western Reserve University, Cleveland.

Dr. Clyde L. Randall, chairman, Department of Obstetrics and Gynecology, University of Buffalo.

Dr. John G. Masterson, assistant professor of obstetrics and gynecology, State University of New York College of Medicine, New York City.

Surgery

Speakers for the Section on Surgery will include the following:

Dr. Fred Coller, chairman of the Department of Surgery and professor of surgery, University of Michigan, Ann Arbor.

Dr. Deryl Hart, professor of surgery, Duke University, Durham, N. C.

Dr. Richard B. Cattell, director of surgery at the Lahey Clinic, Boston, Mass.

An all day program for doctors' wives has been arranged by the host auxiliary.

* * *

Columbus Academy Announces "Clinic Day" Nov. 1

The Columbus Academy of Medicine has announced plans for the second annual "Clinic Day" program to be held Saturday, November 1 at the new Franklin County Veterans Memorial Building,

(Continued on Next Page)

(Columbus Academy—Continued)

300 W. Broad Street in Columbus. Interested physicians of other counties are invited to attend.

The program announced by Dr. Arthur G. James, general chairman, includes nine out-of-state speakers. Final details will be announced in other issues of *The Journal,* and plans for pre-registration will be given.

Registration will begin at 8:30 a.m. with the first program feature at 9:30. The following speakers with the topics on which they will speak have been announced:

Morning Program

Dr. Paul Hodges, professor of radiology, University of Chicago, "Radiation Hazards in medicine."

Dr. Ray W. Gifford, consultant, Section on Medicine, Mayo Clinic, Rochester, Minn., "Fat, Diet and Atherosclerosis."

Dr. Rachmiel Levine, chairman, Department of Medicine and director of metabolic and endocrine research, Michael Reese Hospital, Chicago, "Newer Agents in Diabetes."

Dr. Robert J. Samp, Department of Surgery, Tumor Clinic, Wisconsin University School of Medicine, "Prevention of Cancer, Forty Possible Means."

Afternoon Program

Dr. Joseph E. Murray, Boston, Mass., "Experiences with Kidney Transplants."

Panel Discussion on Care of the Advanced Cancer Patient; Moderator, Dr. Charles A. Doan, dean of the Ohio State University College of Medicine.

Panel Collaborators: Dr. George T. Pack, attending surgeon, Memorial Hospital, New York City; Dr. Chester Southam, associate, Sloan-Kettering, New York City; Dr. Bronson S. Ray, professor of neurosurgery, Cornell University, New York City; Dr. James W. Carpender, professor of radiology, University of Chicago.

* * *

Day Course on Rheumatic Diseases At OSU on Sunday, Oct. 19

Third Annual Session on Rheumatic Diseases will be held on the Ohio State University campus on Sunday, October 19, from 9:30 a. m. to 3:30 p. m. Registration fee will be $5.00 which includes the price of the luncheon. The program will be presented in the Auditorium, Ohio Union.

The conference is sponsored by the National Institute of Arthritis and Metabolic Diseases of the National Institute of Health and the Franklin County Chapter of the Arthritis and Rheumatism Foundation.

Guest lecturer will be Dr. Joseph Bunim, director, National Institute of Arthritis and Metabolic Diseases, Bethesda, Md.

In addition, there will be panel discussions and presentations by other guests and by members of the staff of the Division of Rheumatic Diseases, Department of Medicine, Ohio State University College of Medicine.

Subjects to be covered by the speakers and panelists will include the following: "Scope and Distribution of Rheumatic Diseases," "Osteoarthritis," "Gout," and "Rheumatoid Arthritis and the Other Collagen Diseases."

Several exhibits will be presented including displays on the following: "Serologic Diagnosis of Rheumatic Diseases," "Personality Factors in Rheumatoid Arthritis" and "Aids for the Disabled."

Physicians attending the conference will be eligible for postgraduate credit from the American Academy of General Practice. The course is listed as an approved postgraduate course by the AMA.

Those planning to attend should notify those in charge and request a luncheon reservation by writing to: Division of Rheumatic Diseases, Department of Medicine, Room 103-B, Kinsman Hall, Ohio State University, Columbus 10.

Officers of the Northwestern Ohio Medical Association have announced that the usual meeting of that organization will not be held this year. Plans are being formulated for a meeting in 1959.

Bunts Educational Institute of Cleveland Schedules Courses in 1958-1959

The Frank E. Bunts Educational Institute, affiliated with the Cleveland Clinic Foundation, 2020 East 93rd Street, Cleveland 6, has announced a series of postgraduate courses for the academic year 1958-1959. Details may be obtained by writing Charles L. Leedham, M. D., director of education, at the foregoing address. Dates and topics are as follows:

November 20-21—**Advances in Medical Technology.**

December 4 through April 9, 1959 (Thursday evenings)—**Physics of Radiology.**

December 10-11—**Recent Advances in Surgery.**

January 14-15, 1959—**Neuropsychiatry.**

February 11-12, 1959—**General Practice** (sponsored by the Cleveland Chapter of the American Academy of General Practice.

March 11-12, 1959—**Medical Progress and Its Relationship to Dentistry** (Sponsored by the Cleveland Dental Society).

May 13-14, 1959—**Newer Developments in Gastroenterology.**

Akron Doctors Teach in Traffic School . . .

Unique Traffic Safety Program Has the Assistance of Summit County Medical Society; Similar Projects Can Be Started in Other Counties

Editor's Note:

The medical profession through its County Medical Societies has been asked by The Council of the Ohio State Medical Association to take an active part in the Ohio program on traffic safety. This story tells how one County Medical Society—the Summit County Medical Society—has gone about it to do the job. A program like the one starting in Akron can be initiated in most of the other counties of the state. All County Medical Societies please note!

FIFTEEN-HUNDRED accident-prone traffic violators called together by Akron Municipal Court into a silent and sometimes sullen audience are the targets for the Summit County Medical Society's new Traffic Safety Committee. "These folks," says Dr. Paul L. Weygandt, Committee Chairman, "are somewhat of a challenge."

Dr. Weygandt will lead four other orthopedic men on the committee in a detailed presentation of case histories and crash experiences to this group in 13, one and one-half hour sessions between this September and next August. The doctors join a "faculty" that includes men from Ohio State Highway Patrol, the coroner's office, the city law department and prosecutor's office, local auto insurance and trucking companies.

The school is operated by the Akron Junior Chamber of Commerce which, with Judge Thomas M. Powers, organized it in 1953. It will meet every Monday night this year at an Akron University Building with doctors taking every fourth session.

According to committee member Dr. William L. Davis, "It's that kind of tangible project that takes safety programs out of people's speeches and puts them on the level of action."

School Curriculum

Here's what will take place at the school:

1. As noted above, the physicians will cover traffic injuries with slides of local casualties, case histories, a 16 mm film from Ford Motor Company entitled "On Impact," literature on driving attitudes and safety devices.

2. The insurance men will thoroughly treat with the "What and Why of Ohio's Financial Responsibility Law" and the results of non-compliance.

3. The law officers will offer reviews of the laws that brought the students to the school. "This," says Dr. James W. Parks, another doctor-instructor, "usually results in a change in attitude by a resentful offender."

4. The trucking company people will present defensive driving techniques and deal with driving attitudes. They also will use films and be aided by high school driver-training instructors.

Look for the Best

Seconding Dr. Davis' remarks on the tangible nature of the school, Dr. J. G. Roberts, on the society's traffic team, pointed out that doctors can best become part of important programs already organized in their communities. He advises: "Look around you for the best. Then join up and work. Steer clear of the lip-service-only projects." This was the technique the Summit County Medical Society has used to get something done about traffic safety after its Council called for action last January.

"You don't want to go off halfcocked but as the state Council has said too, the medical community does want to make a move on this front. Check your local library reference division, the Ford Company, Cornell University, the American College of Surgeons and your own files for facts. Do it carefully. Then present the positive solutions you can conceive. It works." This is the statement of Dr. B. K. Rothmann, committeeman in charge of research. He pointed out in conclusion that the 13 sessions to be handled by the five doctors only mean two or three evenings for each member and that such a program need not be confined to large county societies.

Akron Jay-cees plan to print and distribute in the near future as a public relations project a booklet on the school which will include a section on doctor participation. This will be available from the Summit County Medical Society for all interested doctors, Dr. Weygandt says.

Clevelander Takes New Post

Samuel Whitman, executive director of the Cleveland Mental Health Association for 11 years, has left that post to become executive director of the Cleveland Hearing and Speech Center affiliated with Western Reserve University.

JOIN THE PARADE!

* * *

Deadline for Enrolling in Group Life Insurance Plan of Ohio State Medical Association Approaching; Better Send in Your Application at Once

* * *

Now is your chance to get into this *low-cost* but *generous* insurance program *without showing evidence of insurability* . . . No assurance that *deadline* of enrollment period will be extended beyond *September 18* . . . You'd be wise to snap up right now this opportunity to *supplement your present insurance program with unbeatable coverage* by one of Ohio's . . . the nation's . . . finest insurance companies . . .*Union Central, Cincinnati* . . . Join the hundreds of members who have filed an application . . . Open to all members under 75 years of age.

* * *

COMPLETE THE APPLICATION FORM MAILED TO YOU
ABOUT JULY 18 . . . MAIL IT TO

TURNER AND SHEPARD, Inc.

20 South Third Street, Columbus 15

Complete details on plan available from Turner and Shepard on request

Ohio's Crippled Children's Services . . .

State Agency Modifies Some of the Policies and Summarizes Existing Rules in Regard to Eligibility for Care Paid For from Public Funds

BECAUSE of questions raised recently concerning the policies of the Division of Social Administration with respect to the care of crippled children, the Division has summarized, with some modification, the eligibility factors which are now in effect. The changes have the approval of the Advisory Council of the Division and are based upon the limited budget under which the Crippled Children's Service operates and the need to give increasing costly rehabilitative care to more children.

1. Financial Need

The child's family must be unable to provide care taking into account the resources of the family and the extent of the medical requirements. When a case is re-evaluated, financial eligibility is determined in exactly the same way as in a new case. If the anticipated cost of care in the future is such that the family should be able to meet the expense, the child will be discharged from state care. State nurses will continue to give consultation to local health agencies even though the cost of care is not being paid by the state.

2. Prognosis

Cases which offer a poor prognosis will not be accepted for care. If there is a poor prognosis at the time the annual medical re-evaluation is submitted, children will be discharged from care. Children will not be accepted if the social information, psychological report, or other information shows that the child has poor chances of making an adjustment.

No case will be accepted for custodial care only or continued under care for this purpose.

3. Cerebral Palsy

a. No case will be accepted in the future unless there is a psychological or a developmental report available to indicate the general intelligence level of the child. If no other report is available, this can be paid for by Crippled Children's Services.

b. In any severely involved case there must be an evaluation by a Cerebral Palsy Center team giving in detail the possibilities for rehabilitation. The team should include in addition to the physician, a physiotherapist, occupational therapist, and psychologist. If such an evaluation is not otherwise available, it can be paid for by Crippled Children's Service.

c. The Division is now planning to request an evaluation by a Cerebral Palsy Center team for each severely involved child who has been receiving care for three years or more. Each case will be considered on the basis of the evaluation of the team and of other information from the point of view of possible rehabilitation. If possibilities for improvement are slight, the child will be discharged from state care.

d. All new cases are being accepted on the basis of a trial period. The length of the trial period will vary from six months to one year depending upon the age of the child and the information available. An evaluation will be requested from a center at the end of the trial period. Cases in which the prognosis is regarded as fair to good may be accepted for a period of two years at the end of which time a complete evaluation will be made.

4. Time Limitation on Crippled Children's Service

With the exception of cleft palate cases, a five year period of care on the Crippled Children's Program is regarded as the maximum. Each child who has now been receiving care for five years or more will be evaluated by the medical director and cases will be evaluated in the future at least at the end of a five year period. Only those situations will be continued in which there is a clear and present need for service which cannot otherwise be provided.

5. Congenital Abnormalities

Infants will be accepted for surgical care on an emergency basis when there is a congenital abnormality other than an orthopedic anomaly or a need for plastic surgery, under the following conditions:

a. The surgery is performed by a trained pediatric surgeon who meets the requirements of board certification.

b. The prognosis must be reasonably good.

c. Approval of hospitalization will be for a maximum of 30 days only.

6. Burn Cases

Since the Crippled Children's Program is not a general medical program, burn cases will only be accepted after the acute period is past. The Di-

Please Notify Journal of New Address Promptly — Before Moving, If Possible

U.S. postage rates have increased. This means the OSMA will have to pay more to the Post Office Department for returning copies of *The Ohio State Medical Journal* which cannot be delivered because of wrong address.

Therefore, it is hoped that each member will keep the Columbus Office up to date on his mailing address.

If possible, send information on new address before changing locations to give *The Journal* mailing department time to make the change before another mailing.

Members having an office in a downtown building should supply the number of room to assure and expedite delivery.

vision will not pay for hospital care prior to the date on which skin grafting begins.

7. Convalescent Homes

Long periods of hospitalization or of care in convalescent homes are undesirable. No future approval for convalescent care will be given for a period of more than six months and no extension be granted unless it is clearly established that adequate care cannot be provided either in the child's own home or in a foster home.

8. Foster Home Care

a. The Division will pay the cost of boarding home care when the placement is required because the medical service is not available near his home.

b. The Division will pay the difference between the usual board rate of the county and the actual cost of board when the child is placed in a foster home because of the inability of the child's own mother to cooperate in rehabilitation plans. Payment by the Division will be approved for six months to one year with complete re-evaluation at the end of that period.

9. Medical Supplies

Medical supplies such as wheelchairs, special beds and hearing aids will be provided only when there are no other resources available. When requests are made for this kind of item, a local agency will be requested to explore resources such as the local society for crippled children, service groups, Red Cross, etc.

10. Applicable Mainly to
Orthopedic Physicians

The business office will not honor billing for quarterly care except in the following two instances.

a. Billing for a surgical procedure should be only for the fee allowed by the department and includes three months after-care without additional charge.

b. Billing for cases requiring periodic cast changes can be on a quarterly care basis. Such cases may be authorized for one year or any part thereof if the physician asks for such authority from the Crippled Children's Service.

Cincinnati Institute Gets Grant for Antitumor Chemotherapy Study

Eight contracts totalling $859,442 with two pharmaceutical firms and five research organizations for producing possible anticancer agents and for laboratory studies on promising agents were announced by the Public Health Service. One contract was to an Ohio institution.

The Christ Hospital Institute of Medical Research, Cincinnati, will receive $197,019 to compare the antiumor effects of certain alkylating agents. These compounds, so named because of a particular chemical reaction they cause, are useful in restraining the growth of some types of cancer.

The contracts will be administered by the Cancer Chemotherapy National Service Center at the National Cancer Institute, Bethesda, Md.

Public Health Service contracts for cancer chemotherapy work now total approximately $9,750,000.

New Pamphlet by Dr. Palyi

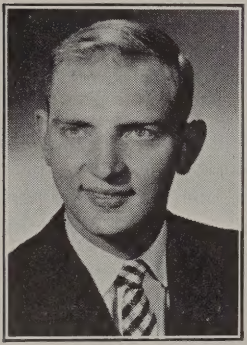
Dr. Melchior Palyi, well known economist and financial expert, has written another informative, 36-page pamphlet entitled "Nationalizations—Ten Years Later." One chapter is devoted to socialized medicine. His searching and enlightening analysis should prove of great interest to the medical profession as well as to thoughtful people in business, public affairs, finance, and education.

The booklet, costing 50 cents, may be obtained from the Heritage Foundation, Inc., 121 West Wacker Drive, Chicago 1, Ill.

Rural Health Activities . . .

Presentation of Rural Medical Scholarship; Lectures on Rural Practice To Medical Students, Preceptorships Among OSMA Committee Projects

THE Ohio State Medical Association Rural Medical Scholarship marked a decade in July with the awarding of the tenth such scholarship to Glenn D. Hisrich, Stone Creek, Ohio, Route 1.



Glenn Hisrich

The 21-year-old Tuscarawas County resident will use the $2,000 scholarship to help finance his medical education at the Ohio State University College of Medicine. He completed his pre-medical education at Ohio State in June.

The scholarship is administered by the Committee on Rural Health and this year's competition, along with other activities of the committee, appear to indicate a growing interest in rural medical activities.

Twenty Apply

Twenty students—a record number—applied for the 1958 award. The scholarship committee noted that the applicants nearly all had considerable background in rural living and rural youth activities. Members of the committee were Dr. H. R. Mayberry, Bryan, chairman; Drs. J. Martin Byers, Greenfield, a past-chairman of the Rural Health Committee; L. W. High, Millersburg, and Kenneth R. Taylor, Pickerington, all members of the Rural Health Committee.

Hisrich is the son of Mr. and Mrs. Vernon G. Hisrich. His father is a farmer and represents Tuscarawas County in the Ohio House of Representatives. His rural interests include extensive activities as a 4-H Club member and junior leader, Farm Bureau Youth Council, Juvenile and Subordinate Grange, Grange Youth Group, church young people activities and others.

Another program of the Committee on Rural Health which appears to be enjoying considerable success is that of providing the 4-H Club Personal Health Record for club members throughout the state.

Nearly 80,000 Used

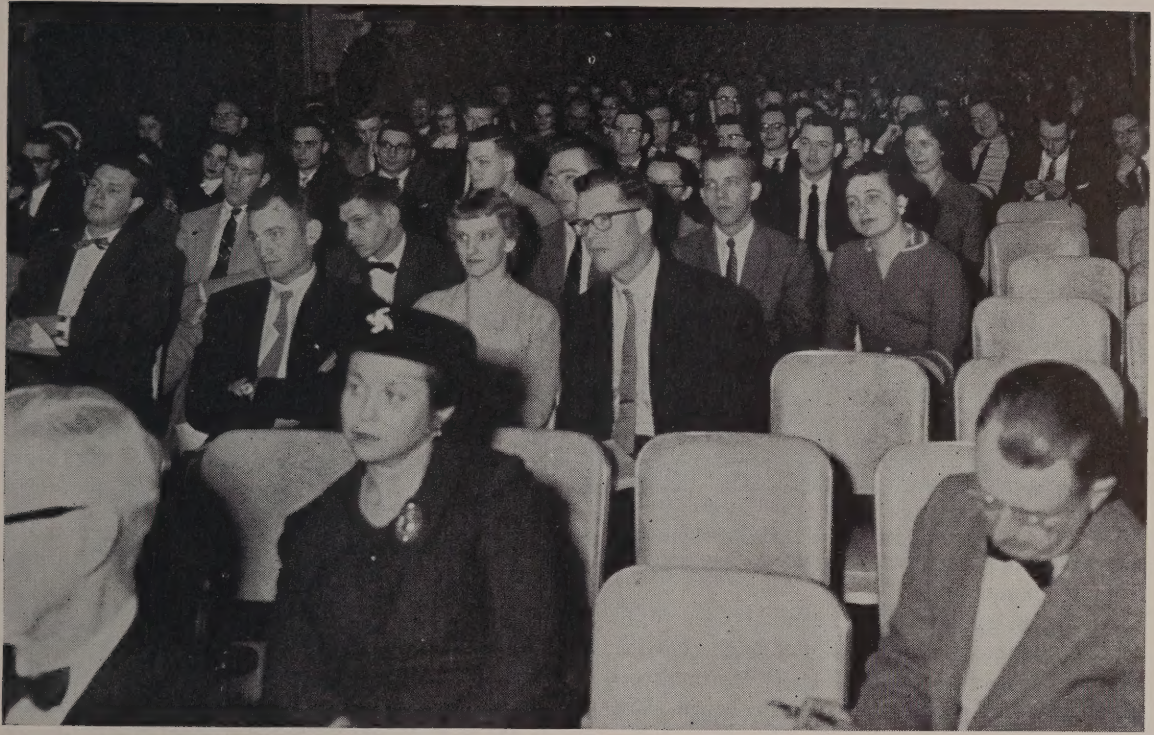
Since this program was activated less than two years ago, nearly 80,000 of the records have been printed by OSMA and distributed to 4-H boys and girls through the State 4-H Office. In conjunction, the committee designed a simplified physical examination form which the state's 4-H Clubs have adopted.

The Committee's series of lectures on the advantages of rural practice was presented in a different format at Ohio State and the University of Cincinnati College of Medicine this year and resulted in increased attendance on the part of medical students and their wives. Instead of having five weekly lectures and a complimentary dinner the sixth week, a one-day program was presented.

The program consisted of a solid afternoon of informal talks and discussions, followed by the dinner the same evening. At Cincinnati, approxi-

This is the group of Ohio State senior medical students and their wives who attended the 1958 lecture program, held at the Ohio Union.

Students Hear Lessons on Practice



University of Cincinnati junior and senior medical students and their wives listen attentively to one of the speakers.

This panel delivered the 1958 "Special Talks to Medical Students" at the University of Cincinnati College of Medicine. Shown during a question and answer session are (left to right) **Dr. G. N. Spears,** Ironton, Rural Health Committee member who since then has been named chairman of the new Committee on Care of the Aged; **Dr. J. Martin Byers,** Greenfield, Rural Health Committee member; **Dr. Frank H. Mayfield,** Cincinnati, OSMA president-elect; **Dr. V. R. Frederick,** Urbana, Rural Health Committee member; **Dr. Richard R. Buchanan,** Wilmington, School Health Committee member, and **Dr. George A. Woodhouse,** Pleasant Hill, OSMA president. At the time of this meeting Dr. Woodhouse was president-elect and Dr. Mayfield was First District Councilor, and acted as chairman of the program.

mately 125 attended the afternoon session and 190, the evening dinner. At Ohio State, some 110 were present for the afternoon meeting and 164 at the dinner.

The one-day program is to be followed next year at Western Reserve, where attendance for the "once-a-week" series last March averaged only 14 students, while dinner attendance climbed to 100.

Active Participation

Presiding at the Cincinnati afternoon session and dinner was Dr. Frank H. Mayfield, president-elect and at that time First District Councilor. Dr. Edwin H. Artman, Tenth District Councilor, presided at Ohio State and Dr. George T. Petznick, Fifth District Councilor, presided at Western Reserve.

Speakers for the evening sessions at the three schools were Past-President Martin (then incumbent president), Mrs. V. R. Frederick of Urbana, Woman's Auxiliary president, and Dr. E. K. Yantes, Wilmington, at that time chairman of the sponsoring committee who since then has resigned from the committee.

Afternoon speakers at Cincinnati were President Woodhouse, Dr. V. R. Frederick, Urbana; Dr. G. N. Spears, Ironton; Dr. J. Martin Byers, Greenfield, and Dr. Richard R. Buchanan, Wilmington.

Afternoon speakers at Ohio State included Drs. Woodhouse and Byers, Dr. Robert E. Reiheld, Orrville, since then appointed chairman of the committee; Dr. John Miller, Orrville, and Dr. Charles H. McMullen, Loudonville.

Participating in the weekly talks at Western Reserve were Drs. Rieheld, Miller, Frederick and Dr. John H. Budd, Cleveland.

Preceptorships Recognized

The Rural Health Committee's preceptorship program, started in 1957 at Cincinnati, resulted in

Dr. E. K. Yantes, Wilmington, Rural Health Committee chairman at the time, speaks on "The Physician and His Community" at the Western Reserve Dinner, and **Mrs. V. R. Frederick,** Urbana, then OSMA Woman's Auxiliary President, speaks on "The Physician's Wife" at the Cincinnati dinner. Dr. Martin, Dr. Yantes and Mrs. Frederick were the speakers for the dinners at all three medical schools.

At the Western Reserve University lectures and dinner, (left to right) **Dr. Robert S. Martin,** Zanesville, then OSMA president, is shown delivering the principal address at the student dinner; **Dr. John H. Budd,** Cleveland, speaks at the session on medical ethics; **Dr. John Miller,** Orrville, speaks at the session on selecting a place to practice and **Dr. George W. Petznick,** Shaker Heights, Fifth District Councilor, welcomes the students to the dinner program.

They Told What Practice Is

Shown addressing medical students during the session for Ohio State University College of Medicine seniors are (left to right) **Dr. Charles H. McMullen,** Loudonville, School Health Committee; **Dr. Edwin H. Artman,** Chillicothe, Tenth District Councilor and chairman for the session; **Dr. Robert E. Reiheld,** Orrville, recently named chairman of the Rural Health Committee, and **Dr. J. Martin Byers,** shown delivering his popular "It's in the Bag" talk.

an invitation to Dr. Reiheld to speak on "Preceptorship Program in Ohio" at the AMA National Conference on Rural Health in Jackson, Miss., last March. Also at the conference, Dr. Yantes and Dr. Robert E. Rakel, then a senior at Cincinnati and national president of the Student AMA, participated in a roundtable discussion of the advantages of rural practice, later printed in *The New Physician.*

Other activities of the committee include presenting subscriptions to *Today's Health* to each county boy and girl 4-H health competition winner in Ohio, sponsoring the state 4-H boy health winner at the National 4-H Club Congress, and assisting in the selection of the boy and girl state winner at the Ohio State Fair.

VA Reports Success on Its Program of Foster Homes for Mental Patients

Veterans Administration's nationwide foster home program to provide a normal home life for recovering mental patients has more than doubled during the past two years, the agency reported.

The total of 1,249 VA mental hospital patients living with their "adopted" families in private homes near the hospitals during 1957 was a 24 per cent increase over the number in 1956 and a 56 per cent increase over the number for 1955.

The hospitals placed 639 patients in the homes during 1957 and reported 219 of those in the program recovered sufficiently during the year to be discharged from hospital rolls.

NFIP Changes Title and Enters New Fields

The National Foundation for Infantile Paralysis has dropped the reference to a specific disease in its title. It will be known in the future as The National Foundation.

Projected plans center on the development of an organized voluntary force in the fields of medical research, patient aid, and professional education, flexible enough to meet new health problems as they arise, the organization states.

The first new goals will be research and eventually a patient aid program in arthritis and congenital malformations. Virus research will be continued and expanded as will the investigations currently being conducted into the disorders of the central nervous system.

No attempt will be made to duplicate the work of other voluntary agencies, Basil O'Connor, President of the organization said.

All five areas of the expanded program will be financed through the traditional March of Dimes conducted annually in January.

Health Commissioner Needed

The Journal has been requested to notify its readers that a health commissioner is needed for Lucas County. Physicians who are qualified and wish to apply for the position or those who wish additional information are invited to write the Lucas County Board of Health, 445 Huron Street, Toledo, Ohio.

Infections in Hospitals . . .

Joint Commission Issues Special Bulletin Enumerating Ways For Solving the Problem; Role of Physicians Emphasized As Important

FOLLOWING are excerpts from Bulletin No. 18 of the Joint Commission on Accreditation of Hospitals on a subject which has become of vital importance to physicians, hospital authorities and hospital patients. *The Journal* believes the question is so crucial that widespread publicity should be given to sound recommendations for solving it.

* * *

Quotes From Bulletin

The presence of infections in hospitals of various kinds will always be with us and we must accept it. To keep these infections to an absolute minimum is of paramount concern to all. This can be done only through continuous education and re-education of all hospital personnel to carry out known control methods with strict discipline at all times.

The Commissioners of the Joint Commission on Accreditations of Hospitals think that the matter is of such grave importance that they urge hospitals to study their own problem and set up systematic controls. The Commission cannot dictate what these controls should be. However, this Bulletin suggests an approach which might be used as a pattern. Each hospital should develop its own methods of study and control to meet its specific needs.

Committee Suggestions

The Commissioners recommend that every hospital have an 'Infection Committee' charged with the responsibility of investigation, control and prevention of infections within hospitals. Membership on this committee should include the medical staff, administration and nursing service personnel. Where possible, participation with community health organizations such as health departments, medical societies and hospital councils is recommended, because the problem is not necessarily confined to the hospital itself. The responsibility of the committee can appropriately include the following:

A. Establishment of definite controls. Control measures must have validity.

B. Establishment of techniques for discovering infections on patients who have left the hospital.

1. Trace source of infection for which a patient may be admitted.
2. Periodic sampling by letter, card, call or visit of discharged patients.

C. Make certain that bacteriologic services in or out of the hospital are available.

D. Establish a system of reporting all infections among patients and personnel and keep records as a basis for studying the source of infections.

Clean Techniques

Clean and aseptic techniques should be practiced on all services of every hospital at all times.

Educate and orient all personnel in the practice of aseptic techniques. An informed worker is a better and a safer worker. It is especially important that physicians not consider themselves the exception to the rule, but both teach and set a good example for all. There can be only one accepted standard of practice.

Control Use of Antibiotics

The medical profession has become increasingly aware of the problems created by the routine and indiscriminate use of antibiotics. Hospital surveys by the Commission reveal that the infection rate in most hospitals using antibiotics routinely is higher than in those not doing so. The common denominator in hospital infections appears to be the resistance of bacteria to antibiotics used on the individual case. From this, the conclusions drawn are that this increase in infections is due to the routine, indiscriminate use of preventive antibiotics in the absence of infection, and the indiscriminate use of antibiotics in the presence of infection without preceding cultures and sensitivity tests. In this latter type of case it is more than useless since without an adequate antibiotic, one may only inhibit the infectious agent and also at the same time stimulate the growth of other organisms which then become pathogenic.

The Human Factor

All the rules, regulations and controls mean nothing if hospital personnel do not constantly check themselves for human errors.

The recognition and elimination of infections in patients and personnel are thought by many to be the most important single facet in the control of infections. No hospital employee with a carbuncle, boil, acne, paronychia, fungus infection, upper respiratory infection, diarrhea, common cold, or in fact any infection, should be allowed in contact with patients. The reverse is true of infected patients. They must be isolated. One of the commonest avenues overlooked is by the physician not notifying the admitting office of the presence of infection already in the patient, or the admitting office or floor nurse not recognizing its very obvious presence on admittance.

There is no single factor responsible for so-called hospital infections. There are many factors and causes and each should be investigated. The Joint Commission cannot supply and does not have literature on special techniques and treatments. For specific articles refer to medical and hospital library indices on the subject.

Physicians of State Institutions Form Professional Association

A new professional organization in Ohio is one closely associated with the task of treating some 28,000 patients in 25 mental institutions and installations in the state, plus the care of thousands in the correctional institutions.

The organization is the Association of Physicians of the Ohio Department of Mental Hygiene and Correction. Dr. Peter J. Brdar, Cleveland, chairman of the Publicity Committee, points out that about a year and a half ago physicians of the Department held an organization meeting in Columbus State Hospital. The Association was formed and now has over a hundred members with Dr. Alvin P. M. Hall, Cleveland Regional Treatment Center, as president.

Subsequent meetings have been held at Columbus State School, Cleveland Psychiatric Institute and Hospital, Scioto View Hospital at the Girls' Industrial School and Orient State Institute. The Association has the support of the Ohio Department of Mental Hygiene and Correction and Dr. Robert A. Haines, Department director.

The ultimate aim of the organization as outlined in the Association's constitution is to contribute toward better patient care, encourage free discussions of mutual problems, foster closer cooperation between local medical societies and the Association, safeguard the professional and economic integrity of the members, promote legislative action to train and retain qualified personnel and to enlighten and direct public opinion in regard to the care and treatment of the mentally ill.

Congressman McGregor Says Nix On Socialized Medicine Schemes

Physicians in the counties of the 17th Congressional District of Ohio (Richland, Ashland, Holmes, Coshocton, Knox, Licking and Delaware) will be interested in the remarks made on the floor of the House of Representatives on July 16 by their Congressman J. Harry McGregor, Coshocton, who is a candidate for re-election. Said Mr. McGregor, as reported by the *Congressional Record*:

"Mr. Speaker, the hearings just completed by the Ways and Means Committee on all titles of the Social Security Act have once again focused attention on the many problems of our wage earners and retired citizens. Of all of our problems, however, none deserves more careful attention than that of adequate medical care for our people, and no one is more eager than I am to see that such medical care is available.

"However, I am at the same time deeply alarmed by some of the proposals now being offered in the Congress, which, I am afraid, could easily lead to a complete socialization of medicine throughout the entire country, with a resulting deterioration in standards of medical care.

"If some of this legislation is enacted, we all will become, in effect, wards of a gigantic bureaucracy which is already far too big for its own good. I am extremely fearful that under this legislation we will lose our freedom of choice in selecting doctors and dentists, and I will do everything within my power to prevent such an outcome.

"Furthermore, I am just as afraid that should some of these programs be accepted, our doctors and dentists will find that their income depends on which political candidates they support, and not on their medical skill. For under these programs, not all doctors (and hospitals) would be allowed to participate, and even those who were allowed to take part in the program would have to depend on some bureaucratic government agency for their fees.

"In my opinion, Mr. Speaker, we cannot expect to find political solutions to serious health problems. We only create more serious difficulties by trying to do so. I am convinced that we can solve our medical problems, but not by imposing compulsory Government programs. Such programs, if enacted, will deprive all people, and especially the aged, of their independence, will force our doctors to rely on the whims of some bureaucratic agency for their livelihood, and will eventually result in inferior health facilities for us all. Mr. Speaker, I have always fought such programs, and I will continue the fight against socialized medicine."

New Members of OSMA

The following are the names of the new members of the Ohio State Medical Association since July 1, 1958. The list shows the county in which they are affiliated, city in which they are practicing or temporary address in cases where physicians are taking postgraduate work.

Columbiana County

Harold E. Ciccarelli, East Liverpool

Coshocton County

Lewis E. Smith, Jr., Coshocton

Cuyahoga County

Joseph Yared, Wickliffe

Franklin County

N. Stanley Lincoln, Falls Church, Virginia
Robert A. Stewart, Columbus

Hamilton County

Paul B. Klatte, Cincinnati

Portage County

Louis V. Castaldi, Ravenna
Kenneth F. Rupp, Kent

Noble County

Frederick M. Cox, Caldwell

Stark County

Marlin L. Abel, Canton
Henrich A. Brinks, Canton
Ernest E. Clark, Canton

Summit County

Robert C. Ackles, Akron

AMA Sponsoring Conference on Problems of the Aged

A nationwide conference to promote a more comprehensive program of medical society action in the field of aging, sponsored by the American Medical Association's Committee on Aging, will be held at the Drake Hotel, Chicago, September 13-14, and will be attended by members of state medical society committees on aging.

Purpose of the two-day conference is to coordinate activities of the medical profession on the national and state levels.

Objectives of such a coordinated program would be:

To seek public acceptance of a proper perspective toward older citizens.

To promote health maintenance and restorative services.

To encourage the training of personnel and the development of facilities for the care of the aged.

To cooperate in developing community programs for senior citizens.

To expand medical and socio-economic research in reference to aging and the aged.

To improve methods of financing health care for the aged.

Among participants will be Dr. Louis M. Orr, Orlando, Fla., president-elect of AMA; Dr. Henry A. Holle, Austin, Texas, a member of the Committee on Aging, and commissioner of Texas State Department of Health; Dr. Leroy E. Burney, Washington, D. C., surgeon general, U. S. Department of Health, Education, and Welfare; Dr. Edwin L. Crosby, Chicago, executive director, American Hospital Association.

Ohio Ranked No. 1 in Mental Facilities Construction

Ohio's $28 million dollars put into construction of new mental hospital facilities in 1957 made the Buckeye State No. 1 in the nation in that construction field, according to Governor C. William O'Neill.

Another $28 million slated for contract awards during 1958 is expected to retain for the state its No. 1 ranking this year, according to Robert A. Haines, M. D., director, Ohio Department of Mental Hygiene and Correction.

In a recent report to members of the Legislature, the Governor said the 1958 program will see the start of mental health facilities equal to the 1957 rate. While a few other states, notably New York, have more funds allocated for such construction than does Ohio, New York's projects failed to reach the "bricks and mortar" stage that would equal Ohio.

Gov. O'Neill noted that Ohio achieved the No. 1 position for the first time in its history. Projects were started during 1957 at Longview State Hospital, Apple Creek, Lebanon, Columbus, Cambridge, Dayton, Gallipolis, Toledo, Cleveland, Tiffin, Marion, Lancaster, Delaware, and Macedonia.

Following approval of a $75 million bond issue in 1955, a five-year construction program was started in 1956 and is scheduled for completion in 1960 and ultimately is expected to involve more than 40 projects.

Osteopaths Delete Name of Still from Objectives

In a revision of its constitution the American Osteopathic Association has removed the name of Dr. Andrew Taylor Still, the founder of osteopathy, from its statement of objectives.

As amended the constitution states that the objectives of AOA "shall be to promote the public health, to encourage scientific research, and to maintain and improve high standards of medical education in osteopathic colleges."

Sponsors of the change stated that the revision was a "desirable modernization to reflect the changes in today's health care." Dr. Carl E. Morrison, AOA immediate past president, said the revision should not be regarded as a change in association policy.

The sentence which was removed stated that "the evolution of the osteopathic principles shall be an ever-growing tribute to Andrew Taylor Still, whose original researches made possible osteopathy as a science."—*Hospitals, J. A. H. A.*

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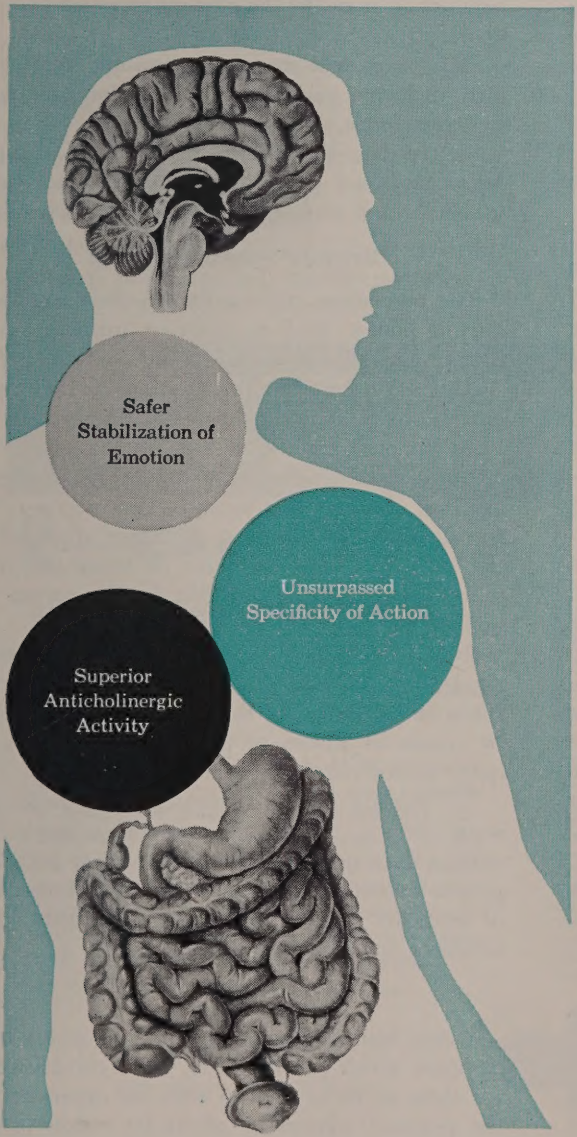

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Pro-Banthīne has won wide clinical acceptance as the most effective drug for controlling gastrointestinal hypermotility and hypersecretion.

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Research in the Service of Medicine.

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Rest Home and Nursing Home Rules . . .

State Agency Adopts Revised Regulations for Licensing and Operation Of Facilities Providing Care for Aged and Physically Infirm Persons

REVISED regulations governing the licensing and operation of rest homes, convalescent homes and boarding homes for the aged and physically infirm have been put into effect by the Division of Social Administration, Department of Public Welfare.

One change in the regulations requires a minimum of 70 square feet per patient in future homes and a minimum of 60 square feet per patient in existing homes.

The new regulations were adopted after an 18-month study. They spell out in more detail, among other things, the extent of medical services these homes must provide.

Medical Consultant

Under Rule 21, "Provisions for Care of Patients," the medical services section provides with regard to nursing homes:

"a) Each nursing home shall have as a medical consultant a physician licensed in the State of Ohio to provide medical care for residents not having an attending physician or for care in case the attending physician cannot be reached in case of emergency and to assume responsibility for the general adequacy of the nursing care rendered in the home.

"b) It is recommended that all residents have a pre-admission chest x-ray. If a chest x-ray cannot be obtained, a series of sputum examinations should be done in lieu thereof.

"c) If new residents are not accompanied by a record of physical findings, diagnosis and signed doctor's orders for treatment, diet, activity, etc., the administrator shall secure this information within 48 hours after admission from the resident's attending physician, or if the patient has none, from the medical consultant for the home.

"d) No medication or treatment is to be given without doctor's orders. If orders are given by telephone, they shall be recorded by the licensed practical nurse or registered nurse on duty with the doctor's name, and the order shall be signed by the doctor on his next visit."

Rest Home Supervision

Under the regulations governing rest homes, the following rules cover medical supervision:

"a) Each rest home shall have a medical consultant licensed in the State of Ohio on call to provide medical care for residents not having an attending physician or for care in case the attending physician cannot be reached in case of an emergency.

"b) All residents shall have a physical examination by a licensed physician before being admitted or within a week after admission. It is recommended that this physical include a chest x-ray or sputum test.

"c) A physical examination shall be completed on each resident once each year. This examination may be completed by the resident's attending physician or, if none, by the medical consultant for the home.

"d) A resident may be responsible for taking own medicine provided the attending physician writes an order to this effect.

"Exception: The requirements of medical supervision shall not apply to non-profit homes established for and maintained by Christian Scientists."

Records System Required

The regulations provide that medical records in nursing homes "shall be prepared, maintained and filed in a manner approved by the Division. They shall be kept for a minimum of one year after discharge or death of the resident."

As for rest homes, the regulations state, "A record of each resident to include name, residence, age, sex, nearest relative and other necessary information shall be kept in a manner approved by the Division. Any medicine or treatment given to residents shall be recorded by the person administering the medicine or treatment."

Rule 17 defines a nursing home as "any place, residence or home used for the reception and care, for a consideration, of three or more persons who by reason of illness or physical impairments require skilled nursing services.

"A nursing home is licensed to provide personal services as required and other service requiring nursing skills which the ordinary untrained person cannot administer, such as administration of medicine * * *. A nursing home may admit residents not requiring nursing care."

Rest Home Defined

A rest home is defined as "any place, residence or home which provides care, for a consideration, for three or more persons who are dependent on the personal services of others by reason of age and physical or mental impairments but who do not require skilled nursing services."

A complete copy of the laws, rules and regulations governing licensing and operation of such homes may be obtained by writing the Division of Social Administration, Department of Public Welfare, Ninth and Oak Streets, Columbus.

On January 1, 1959, a city ordinance becomes effective in Columbus that is somewhat parallel to the state regulations.

Booklet Gives Results of Hill-Burton Survey

Results of a two-year study of the Hill-Burton Hospital Survey and Construction Program is available in booklet form from the Committee on Medical and Related Facilities of the AMA Council on Medical Service.

In addition to reviewing the legislative background of the act and a voluminous amount of other data, reports on field surveys made in the following states are included: Arkansas, California, Connecticut, Georgia, Illinois, Iowa, Kentucky, Maryland, Michigan, Mississippi, Montana, New Jersey, Oregon, and Washington.

A limited number of copies will be available to individual physicians and medical societies.

General Fancher Named Director of Health Service at Ohio State

Ohio State University's Board of Trustees has named as director of the University Health Service Brig. Gen. Paul S. Fancher, who retired July 1 as commanding officer of Letterman Army Hospital, San Francisco, Calif. Effective September 1, he succeeds Dr. John Wilce who retired this summer after a distinguished career at OSU.

A native of Ohio, General Fancher is a 1925 graduate of Ohio Wesleyan University and received the doctor of medicine degree from Ohio State in 1930. His assignments before going to Letterman included that as chief of the Department of Medicine, Walter Reed Army Hospital. During World War II he commanded the 76th General Hospital in this country, England and Belgium. He is a fellow of the American College of Physicians and a diplomate of the American Board of Internal Medicine.

John R. Wilson, D. D. S., has been named associate dean and professor, College of Dentistry, Ohio State University. He formerly was chairman of the Division of Periodontology in the College. Dr. Wilson succeeds Hamilton B. G. Robinson, D. D. S., who left Ohio State to accept appointment as dean of the School of Dentistry of the University of Kansas City.

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*Chappel, C.C., J.A.M.A., 162: 1414, (Dec. 8) 1956

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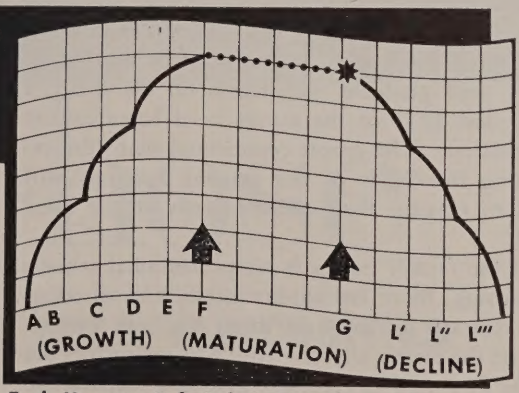

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Ohio's Nursing Future . . .

Survey Shows Need for Increased Number of Administrators, Teachers And Supervisors To Meet Projected Needs of the Profession by 1970

OHIO needs considerably more nursing teachers, administrators and supervisors on the baccalaureate and master's degree level to meet its future nursing requirements, according to a report of the Division of Nursing, Ohio Department of Health.

The report was written from a comprehensive survey to determine the state's nursing needs by 1970. A preliminary report of the study indicated that registered nurses in the state will have to be increased by 36,000 in the next 12 years to meet the need, as was reported in the July issue of the *OSM Journal* (p. 943.)

The report details the findings of a comprehensive survey conducted by questionnaire, as well as data from the study by Frieda I. Stewart, Associate Professor of Nursing, Ohio State University, on "The Increasing College Age Population of Women in Ohio; Implications for Nursing Education in Ohio."

Nurse Education

Approximately one-third of the state's general hospitals, having about 50 per cent of the total beds in Ohio, were surveyed. It was discovered that 708 of the teachers, administrators, and supervisors need graduate preparation on the master's level; and 1073 of the nurses need baccalaureate preparation. The report commented that "the remaining two-thirds of our general hospitals will need to prepare their present staffs at the same level."

Of the faculty nurses in 62 professional schools of nursing, there are approximately 115 directors and assistant directors; of these, 58 lack preparation on the master's level. And 633 instructors out of the 734 need to complete graduate preparation.

In view of information obtained, the report added, "the college and university controlled programs have better prepared faculty than the hospital or diploma programs."

In the 16 approved schools of practical nursing it was found there are approximately 18 directors and assistant directors who should have preparation on the graduate level. In addition, 71 of the 76 instructors and supervisors need graduate preparation.

Nursing, Maternity Homes

A selected sample of 125 nursing homes of the state's 800 licensed nursing homes was surveyed and only 37 returned the questionnaire. The findings of this survey were thus inconclusive. However, the report estimated that 550 nurses are needed in nursing homes, this figure being based on the need for a minimum of one registered nurse in each nursing home offering nursing care of the sick. "The qualifications of these nurses at this time," the report continued, "is that of a staff position. The nurses would require preparation on the diploma level."

In the 20 maternity homes surveyed, it was learned there were 30 nursing positions listed as either supervisory or administrative; only one nurse so classified has a baccalaureate. "It would seem," the report stated, "that, of these positions, six should have graduate preparation and 24 would require . . . a minimum of a baccalaureate."

The state's 22 mental hospitals have 36,000 beds and approximately 410 nurses employed in administrative and supervisory positions. (But there are 473 unfilled positions, the hospitals indicated.) Of the 138 administrative and supervisory personnel, about 8 per cent have completed the master's degree. Only 1.1 per cent of the 272 head nurses and assistant head nurses have the minimum preparation of the baccalaureate degree.

The Ohio census of industrial nurses as of January, 1957, indicated 1350 nurses were employed in industry. Every nurse working alone, or as a supervisor of multi-nurse service in industry, should have a baccalaureate degree as a minimum preparation, the report said. Thus 848 industrial nurses currently employed need this level of academic preparation.

Of the 296 public health nursing agencies in Ohio, there are approximately 131 nurses in a supervisory or administrative capacity; 107 of these still need preparation on a graduate level. And of the approximately 1122 nurses employed in staff positions, 893 still need baccalaureate preparation.

Nursing Needs

In the 62 schools of nursing in Ohio, enrollment reached 6300 in 1956. If the present rate of increase (one tenth of one per cent a year) continues, enrollments can be expected to reach 12,000 by 1965 and 17,000 by 1970.

The task of providing instructors for this group should have high priority in future plans, the re-

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port urged. Since 1951 only 104 nurses have completed a graduate program in Ohio universities.

Population increase alone requires that Ohio supply a considerable number of nurses to maintain the current ratio of 232 nurses per 100,000 population. To improve nursing services to Ohio's population, it is recommended the ratio be increased to 300-350 per 100,000.

1970 Projection

To achieve this ratio by 1970, Ohio will need 40,000 nurses. In order to have 40,000 nurses active in 1970, Ohio must provide 2770 nurses annually.

In four fields of nursing—hospital, public health, industrial health and health teaching—23,500 nurses must be added in the next 13 years to meet suggested standards. Of the number, approximately 12,500 need preparation at the baccalaureate level and 5,000 need graduate preparation.

A copy of the Ohio report may be obtained by writing the Division of Nursing, Ohio Department of Health, Ohio Departments Building, Columbus 15, Ohio.

Dr. Keller Heads State Chronic Diseases and TB Divisions

Martin D. Keller, M. D., M. P. H., has been named chief of the Divisions of Chronic Diseases and Tuberculosis in the Ohio State Department of Health. He also is to serve on the faculties of medicine and preventive medicine at Ohio State University.

Formerly with the Epidemic Intelligence Service of the United States Public Health Service, Dr. Keller first came to Ohio on loan as an epidemiologist in 1953. During 1954 he served as acting chief in the Division of Communicable Diseases in the State Department of Health.

During the last three years he has been doing graduate work at Columbia University and the Veterans Administration Hospital in New York, during which he completed requirements for specialty in internal medicine and also obtained his master's degree in public health.

Dr. Keller did his undergraduate work at Yeshiva University, earned a Ph. D. in bio-chemistry at New York University, and was awarded his medical degree by Cornell University Medical College.

The University of Pittsburgh has established a health law center within the Graduate School of Public Health. Its purpose is to pursue studies concerning the legal aspects of medicine, dentistry, nursing, public health, hospitals and medical care.

Cook County Graduate School of Medicine

INTENSIVE POSTGRADUATE COURSES

STARTING DATE — FALL, 1958

SURGERY—Surgical Technic, two weeks, Sept. 29, Oct. 27. Surgery of Colon & Rectum, one week, Sept. 22, Oct. 27. Basic Principles in General Surgery, two weeks, Oct. 13. Gallbladder Surgery, three days, Nov. 3. Surgery of Hernia, three days, Nov. 6. General Surgery, two weeks, Nov. 10; one week, Oct. 27. Fractures & Traumatic Surgery, two weeks, Dec. 1. American Board Review Course, two weeks, Nov. 10. Blood Vessel Surgery, one week, Oct. 20.

GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, two weeks, Oct. 13. Vaginal Approach to Pelvic Surgery, one week, Oct. 6. General & Surgical Obstetrics, two weeks, Oct. 27.

MEDICINE—General Review Course, two weeks, Oct. 20. Electrocardiography, two-week basic course, Oct. 6. Gastroscopy & Gastroenterology, two weeks, Nov. 3. American Board Review Course, one week, September 29 — (Oversubscribed — Available again in Spring, 1959).

DERMATOLOGY—Clinical & Didactic Course, two weeks, Nov. 3.

UROLOGY—Two-week intensive course, Oct. 13. Ten-day practical course in Cystoscopy by appointment.

RADIOLOGY—Diagnostic X-Ray, two weeks, Dec. 1. Clinical Uses of Radioisotopes, two weeks, Sept. 29.

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Ointment: Tubes of ⅛ oz. and ½ oz. (with applicator tip) for ophthalmic or dermatologic application.
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Provides comprehensive bactericidal action effective against virtually all bacteria likely to be found topically.

Ointment: Tubes of ½ and 1 oz. and tubes of ⅛ oz. with ophthalmic tip.
Ophthalmic Solution: Bottles of 10 cc. with sterile dropper.
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Ointment: Tubes of ½ oz., 1 oz. and ⅛ oz. (ophthalmic tip).

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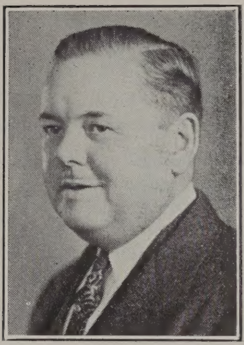
In Memoriam . . .

Ralph L. Rutledge, Sr., M. D., recently of Alliance, Past-President of the Ohio State Medical Association, died on July 23 at the age of 65. Dr. Rutledge served as President of the OSMA for the term 1947-48. He had previously served on The Council as Councilor for the Sixth District beginning in 1939.


Dr. Rutledge

Dr. Rutledge received his medical degree from the University of Pittsburgh in 1916 and took postgraduate work at Harvard Medical School, the New York Orthopedic Hospital and the New York Postgraduate Medical School. During World War I he served with the Army Medical Corps in France in the grade of captain.

His practice in Alliance began in 1919 and continued until his retirement last November. He was a past-president of the Stark County Medical Society and served in numerous other capacities in his local organization. Professional organizations to which he belonged in addition included the American Medical Association, the American Fracture Association and the American Academy of General Practice. He was an elder in the Presbyterian Church, a past-president of the Rotary Club and was active in a number of Masonic bodies.

Survivors include his widow, a daughter and a son, Dr. Ralph L. Rutledge, Jr., of Alliance.

Emmett B. Shanley, M. D., New Philadelphia, former member of The Council of the Ohio State Medical Association, died on July 21 at the age of 83. He served as Councilor from the Seventh District from 1930 to 1934.

Dr. Shanley was a practicing physician over a period of 60 years, 57 years in Tuscarawas County. He had been honored with the 50-Year Award of the OSMA. An active participant in medical organization for many years, he was a past-president of the Tuscarawas County Medical Society and served the local organization in many other capacities. Other local contributions include service as registrar of vital statistics for over 50 years. He was a member of the American Medical Association and a member of the Masonic Lodge. Dr. Shanley was a graduate of the Starling Medical College, Columbus, class of 1898. A son survives.

Guy E. Noble, M. D., St. Marys, former member of The Council of the Ohio State Medical Association, died on August 4 at the age of 77. Member of a pioneer family of Auglaize County. Dr. Noble returned to St. Marys to practice immediately upon completion of his medical training in Columbus, where he graduated from the Starling Medical College in 1905. An early believer in organized medicine as a way of upholding the ideals of the profession and protecting the public, he has held every office in the Auglaize County Medical Society, being president in 1947-1948. He also was delegate to the OSMA for many years.

Dr. Noble

Dr. Noble served on The Council as Councilor for the Third District from 1940 to 1946. In his County Society he served for many years as chairman of the important Committee on Legislation, as well as serving on many other local committees. Another local responsibility was that as health officer for St. Marys. His practice included a long term as surgeon for the Nickel Plate and New York Central Railways.

Professional affiliations included membership in the American Medical Association and the American Academy of General Practice. Other memberships included those in the Rotary Club, the Methodist Church and several Masonic bodies. Surviving are his widow, two sisters and a brother, Dr. Walter A. Noble, of Lima.

Greer A. Allen, M. D., Springfield; Meharry Medical College, 1921; aged 64; died July 24; member of the Ohio State Medical Association and the American Medical Association through 1956. Dr. Allen practiced medicine for 32 years in Springfield before his retirement two years ago. He was a member of the Methodist Church. Surviving are his widow, two daughters, a son, three sisters and a brother.

Waldo Z. Baker, M. D., Youngstown; Ohio State University College of Homeopathic Medicine, Columbus, 1918; aged 67; died August 5; member of the Ohio State Medical Association. Dr. Baker practiced his profession for some 40 years in Youngstown. He was a Mason and a member of the Presbyterian Church. Surviving are his widow, a daughter and three sons, one of whom is Dr. Norman Baker, now doing residency work at Mayo Clinic.

Richard P. Bell, Jr., M. D., Cleveland; Western Reserve University School of Medicine, 1945; aged 38; died July 26; member of the Ohio State Medical Association, the American Medical Association, American Academy of Ophthalmology and Oto-Laryngology, Association for Research in Ophthalmology; Fellow of the American College of Surgeons; diplomate of the American Board of Ophthalmology. A native of Lakewood, Dr. Bell practiced in Cleveland and Lakewood area and previously was on the faculty of Western Reserve University School of Medicine. He was captain in the Army Medical Corps during World War II. Affiliations included memberships in the Masonic Lodge, the Westwood Country Club and Nu Sigma Nu. Surviving are his widow, two sons and two daughters; his parents, Dr. and Mrs. Richard P. Bell, Sr.; a brother, Dr. David M. Bell, now with the Army; and a sister.

Theodore A. Campbell, M. D., Wapakoneta; Medical College of Ohio, Cincinnati, 1897; aged 83; died July 8; former member of the Ohio State Medical Association and the American Medical Association. A recipient of the OSMA 50-Year Award, Dr. Campbell practiced for more than 61 years in Auglaize County. A veteran of the Army Medical Corps of World War I, he was a member of the American Legion. Other affiliations included membership in the Woodmen of the World. Survivors include two daughters, a brother and a sister.

Louisa S. Cervone, M. D., Youngstown; University of Wooster, Medical Department, Cleveland, 1900; aged 80; died August 1; member of the Ohio State Medical Association and the American Medical Association. Dr. Cervone retired in 1951 after 50 years of practice in Youngstown and was honored in that same year with the OSMA 50-Year Award. She was active in the Federated Women's Club; the Illalee Club and other groups. Surviving are her husband, Joseph B. Cervone, a daughter, a brother and three sisters.

Carl J. Dillon, M. D., Newark; Starling Medical College, Columbus, 1907; aged 75; died July 30; member of the Ohio State Medical Association and the American Medical Association; past-president of the Licking County Medical Society. A practitioner in Newark for most of his professional career, Dr. Dillon was awarded the OSMA 50-Year button. Active in many local affairs, he was

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a member of the Presbyterian Church, the Elks Lodge and the Modern Woodmen. A brother and sister survive.

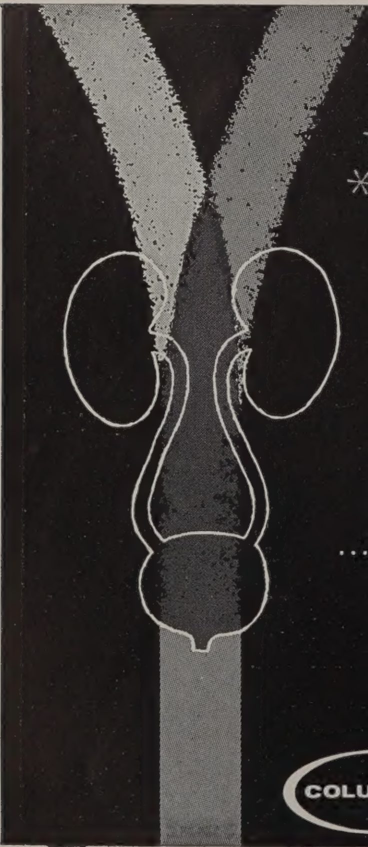
Fred L. Eyestone, M. D., Toledo; University of Maryland School of Medicine and College of Physicians and Surgeons, 1916; aged 65; died July 20; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons. Dr. Eyestone practiced for nearly 40 years in Toledo, having moved there shortly after World War I during which he served with the Army Medical Corps. He was a member of the Episcopal Church. Surviving are his widow, a brother and a sister.

G. Bruno Fliedner, M. D., Cleveland; Western Reserve University School of Medicine, 1910; aged 71; died August 2; former member of the Ohio State Medical Association. A native of Cleveland where his father, the late Dr. Frederich Fliedner practiced before him, Dr. Bruno Fliedner served all of his professional career there, with time out for service in the Army Metdical Corps during World War I. He is survived by a daughter and three sisters.

Harry H. Haggart, M. D., Cincinnati; St. Louis College of Physicians & Surgeons, 1921; aged 66; died July 13; member of the Ohio State Medical Association, the American Medical Association and the American Academy of Ophthalmology & Oto-Larygology; diplomate of the American Board of Otolaryngology; member of the American Society of Plastic and Reconstructive Surgery; member of the Board of the American Rhinologic Society, and a past-president of the Ear, Nose and Throat Society of Cincinnati. Dr. Haggart practiced for 30 years in Cincinnati, having moved there from Bluefield, W. Va., where he practiced for about three years. Surviving are his widow and two daughters.

Herman P. Hyder, M. D., Bentonville; University of Arkansas School of Medicine, 1917; aged 73; died July 23; member of the Ohio State Medical Association and the American Medical Association. Dr. Hyder served a large part of his medical career with the federal government and was superintendent of the government hospital at Nashville, Tenn., before he moved to Adams County. He was a member of the Masonic Lodge and the Methodist Church. Surviving are his widow, a brother and four stepchildren.

Reid P. Joyce, M. D., Xenia; University of Pennsylvania School of Medicine, 1932; aged 50;



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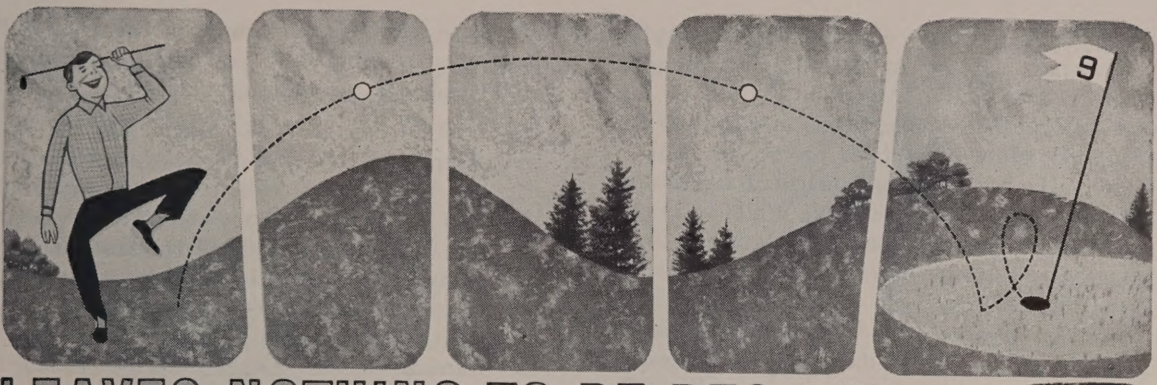

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died July 16; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons; diplomate of the American Board of Surgery. Dr. Joyce moved his practice to Xenia in 1954. He had previously practiced in Sarasota, Florida, Dayton and Ashland. While in Dayton he was one of the founders and editor of the *Montgomery County Medical News*. In Xenia he was chief of the Xenia-Greene County Cancer Clinic. Affiliations included memberships in the Presbyterian Church and the Rotary Club. Surviving are his widow; two sons; his father, Dr. Charles W. Joyce, of Fletcher, Okla.; and three brothers, one of whom is Dr. Frank Joyce, of Denver, Colorado.

Vincent A. Killoran, M. D., Fort Lauderdale, Florida; University of Toronto Faculty of Medicine, 1927; aged 58; died July 26; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Nine years ago Dr. Killoran moved to Florida from Sandusky where he had been in practice about 15 years. He is survived by his widow, a son and a daughter.

Lowell W. King, M. D., Salem; Western Reserve University School of Medicine, 1918; aged 65; died June 29 in a traffic accident; member of the Ohio State Medical Association, the American Medical Association and the American Academy of Ophthalmology & Oto-Laryngology. Dr. King was a practicing physician in Salem for 36 years. A veteran of World War I, he was a member of the American Legion. Other affiliations included memberships in the Masonic Lodge, the Elks Lodge and the Rotary Club. Surviving are his widow, five sons, including Dr. Lowell R. King, and a sister.

Fernand J. Leblicq, M. D., Sandusky; Cleveland-Pulte Medical College, 1913; aged 65; died July 17; former member of the Ohio State Medical Association. Dr. Leblicq practiced medicine in Sandusky for 43 years. He was a member of the Evangelical and Reformed Church, a past-com-

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mander of the local American Legion Post as a veteran of World War I, and past-president of the Lions Club. Surviving are his widow and a daughter.

Charles Walter Manss, M. D., Arlington, Va.; Miami Medical College, Cincinnati, 1902; aged 81; died June 28; former member of the Ohio State Medical Association. Dr. Manss practiced medicine in Cincinnati for 30 years before he retired in 1934. He moved to Virginia about a year ago. Surviving are a son with whom he made his residence, a sister and a brother.

James R. May, M. D., St. Clairsville; Western Reserve University School of Medicine, 1936; aged 48; died July 22; former member of the Ohio State Medical Association and the American Medical Association; member of the American Trudeau Society. Dr. May was a recent health commissioner of Belmont County and formerly practiced in Lakewood and Cleveland. He was veteran of World War II, having served in the Army Medical Corps with the rank of lieutenant colonel. Surviving are his widow, two sons, a daughter, his mother and a sister.

Charles R. Meek, M. D., Lorain; Ohio State University College of Medicine, 1913; aged 71; died August 2; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Dr. Meek was a practicing physician in the Lorain area for 45 years and former local health commissioner. Active in a number of local affairs, he was a member of several Masonic bodies, the Knights of Pythias, the Elks Lodge and the Methodist Church. Surviving are his widow, a son, a daughter, a brother and two sisters.

Claude W. Montgomery, M. D., Sycamore; Ohio Medical University, Columbus, 1900; aged 86; died July 7; member of the Ohio State Medical Association and the American Medical Association. Upon completion of his medical training Dr. Montgomery moved to Sycamore and practiced for a lifetime there. In 1950 he was honored with

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1. Thomas, J. W.: Ann. Allergy 16:128, 1958

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the 50-Year Award of the Ohio State Medical Association. A sister survives.

Bushnell R. Reynolds, M. D., Bakersfield, California; Washington University School of Medicine, 1899; aged 82; died July 10. Dr. Reynolds practiced for many years in Greenwich, Ohio, before he retired about five years ago and moved to California. A son with whom he made his residence in California and a brother in Greenwich survive.

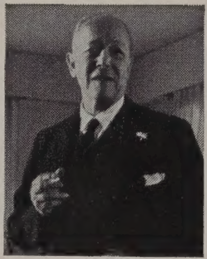
Robert A. Stack, M. D., Lorain; University of Cincinnati College of Medicine, 1920; aged 63; died August 4; member of the Ohio State Medical Association, the American Medical Association, the Industrial Medical Association; Fellow of the American College of Surgeons. Upon completion of residency training in Cincinnati and New York, Dr. Stack returned to his native Lorain to begin practice in 1923. He was a veteran of World War I, having served in the Army Air Corps. His professional work included membership on the American Cancer Society executive Board and the Lorain Board of Health. Other organizations to which he belonged included the Moose Lodge, the Elyria Country Club, the New York City Athletic Club, the Spring Valley Country Club, the Elyria and Lorain Yacht Clubs. He also was a member of the Catholic Church. Survivors include his widow, five sons, a daughter, two brothers and four sisters.

Frank R. Stansbury, M. D., Cincinnati; Pulte Medical College, Cincinnati, 1906; aged 79; died July 16. Dr. Stansbury practiced for many years in the Oakley section of Greater Cincinnati. He was a member of the Baptist Church. Surviving are his widow, a step-son, two brothers and two sisters.

Ohioans Certified by American Board Of Obstetrics and Gynecology

The American Board of Obstetrics and Gynecology has announced certifications of the following Ohio physicians:

Drs. Otis G. Austin, Medina; Matthew R. Biscotti, Parma; Lloy DeF. Bonar, Mansfield; Louis R. Chaboudy, Portsmouth; Eugene R. Clumpner, Lakewood; Christian J. De Winter, Akron; William S. Dietrichson, Dayton; Naoma D. Green, Springfield; Albert C. Lammert, Cleveland; David E. Leavenworth, Canton; L. Brooks Mehl, Cuyahoga Falls; Jack P. Mercer, Lorain; William B. Merryman, Columbus; Walter B. Rugh, Cincinnati; Emmett D. Simonson, Cleveland.



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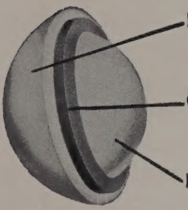

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Rules Listed for Healthful Foreign Travel

Physicians often are called upon to advise patients on health precautions to be taken before and while touring outside of the United States. Here are some common sense pointers on the subject compiled by Ray Vicker, a Chicago Writer, in the August issue of *Today's Health.*

Before leaving, a person must have a smallpox vaccination, since a vaccination no older than three years is necessary for re-entry into the United States. Moreover, many countries require a vaccination for entry.

A few Latin American countries also require a personal health certificate issued by a physician. Even if a certificate is not necessary, it might be advisable to have a physical examination prior to departure, Vicker said. The doctor can recommend any special precautions for health protection and can advise on the preparation of a first aid kit.

If a person is going to a country outside Europe, he should have yellow fever and cholera immunizations and perhaps a tetanus shot, he said.

Vicker noted that drinking water is safe in most of the big cities of Europe and many of the small. However, when in doubt, a person should drink bottled water. Ice cubes should be skipped unless they are known to be made from pure water. If water cannot be boiled it can be treated with a chemical in tablet form.

Stomach upsets, common to travelers, are often caused by contaminated food or water, eating indiscretions, or eating habits upset by time changes. Vicker suggested that a person take with him Kaomagna, Kaopectate and bismuth-paregoric preparations for such difficulties. (Obviously, the doctor may wish to advise the individual patient on what remedies to take.)

Unless milk is boiled, it should be avoided in many countries. The exceptions are Australia, New Zealand, Great Britain, Holland, Belgium, Switzerland, and the Scandinavian countries. In India, Malaya, and certain other countries, hot milk is served on cereal. This is a sign that the milk has been boiled, the author said.

Ice cream, butter, and fresh cheese are also taboo if the milk in a country is unsafe. And in the tropics, the taboo should be extended to include cold pastries, custards and meringues.

In preparing a first aid kit, a traveler should include sunburn lotion, aspirin, lotion for insect bites, and adhesive bandages, in addition to remedies for stomach upsets, seasickness, and malaria.

If a person wears glasses, he should take an extra pair or a prescription for his lens, Vicker added.

Central Ohio Blue Cross Now Covers N and M Hospitalization

Central Hospital Service Association (Blue Cross plan in Central Ohio) now offers hospital service covering mental and nervous disorders, alcoholism and drug addiction, the association announced.

The new coverage is available only to group subscribers and offers 30 days' hospital service a year. Time spent in a hospital under the plan, however, will be deducted from the total to which the policy holder is entitled under his regular hospitalization contract.

Rates for full service coverage on the new contract will be 50 cents a month for individuals or 95 cents a month for family contracts.

Mid-West Allergy Program

The Mid-West Forum on Allergy will hold its annual meeting on December 6 and 7, 1958 at the Sheraton-Cadillac Hotel, Detroit, Michigan. This meeting of the Forum is sponsored by the Michigan Allergy Society. For further information write to John M. Sheldon, M. D., General Chairman, in care of the University Hospital, Ann Arbor, Michigan.

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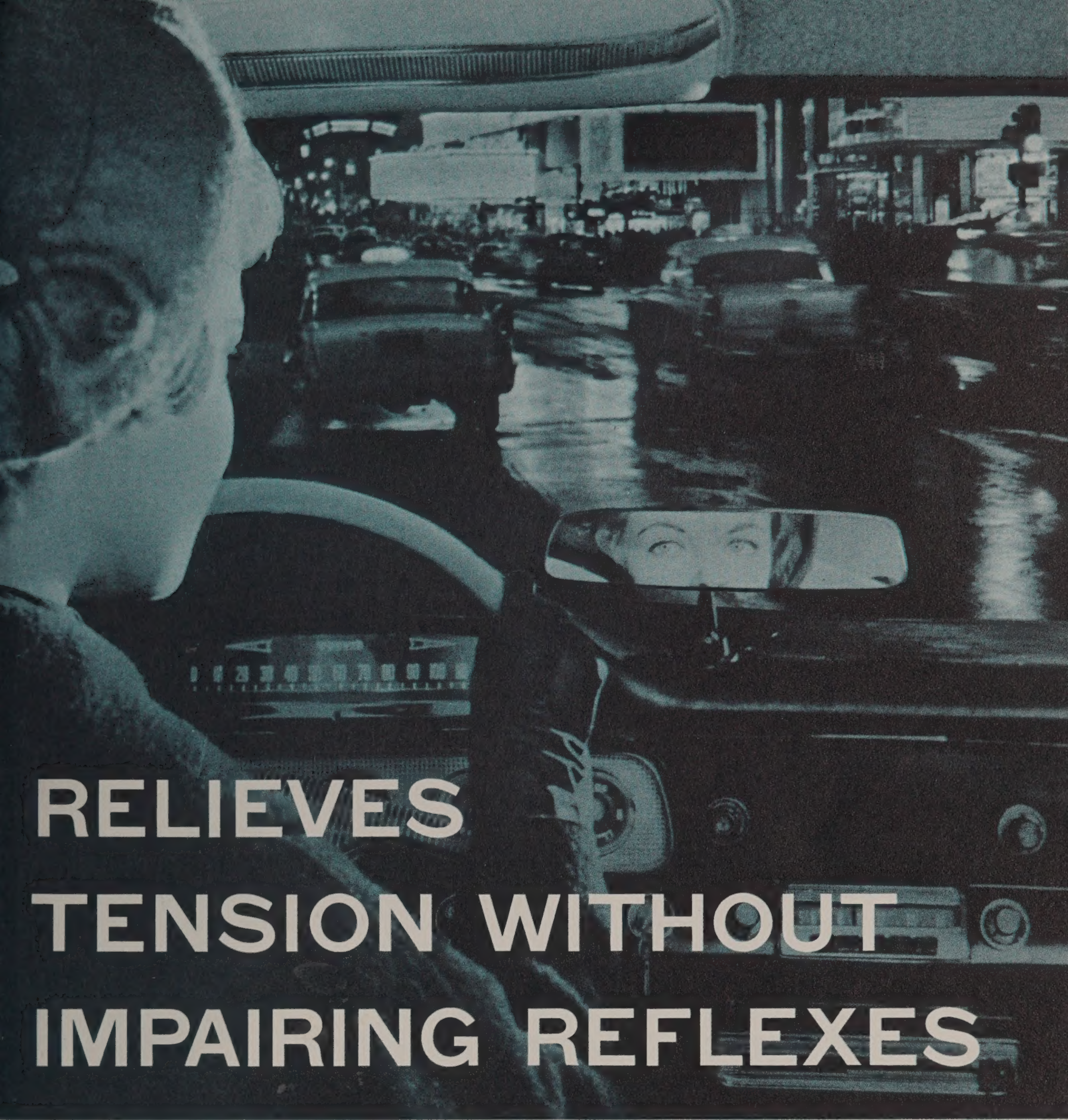

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**Marquis, D. G., Kelly, E. L., Miller, J. G., Gerard, R. W. and Rapoport, A.: Ann. New York Acad. Sc. 67: 701, May 9, 1957.*

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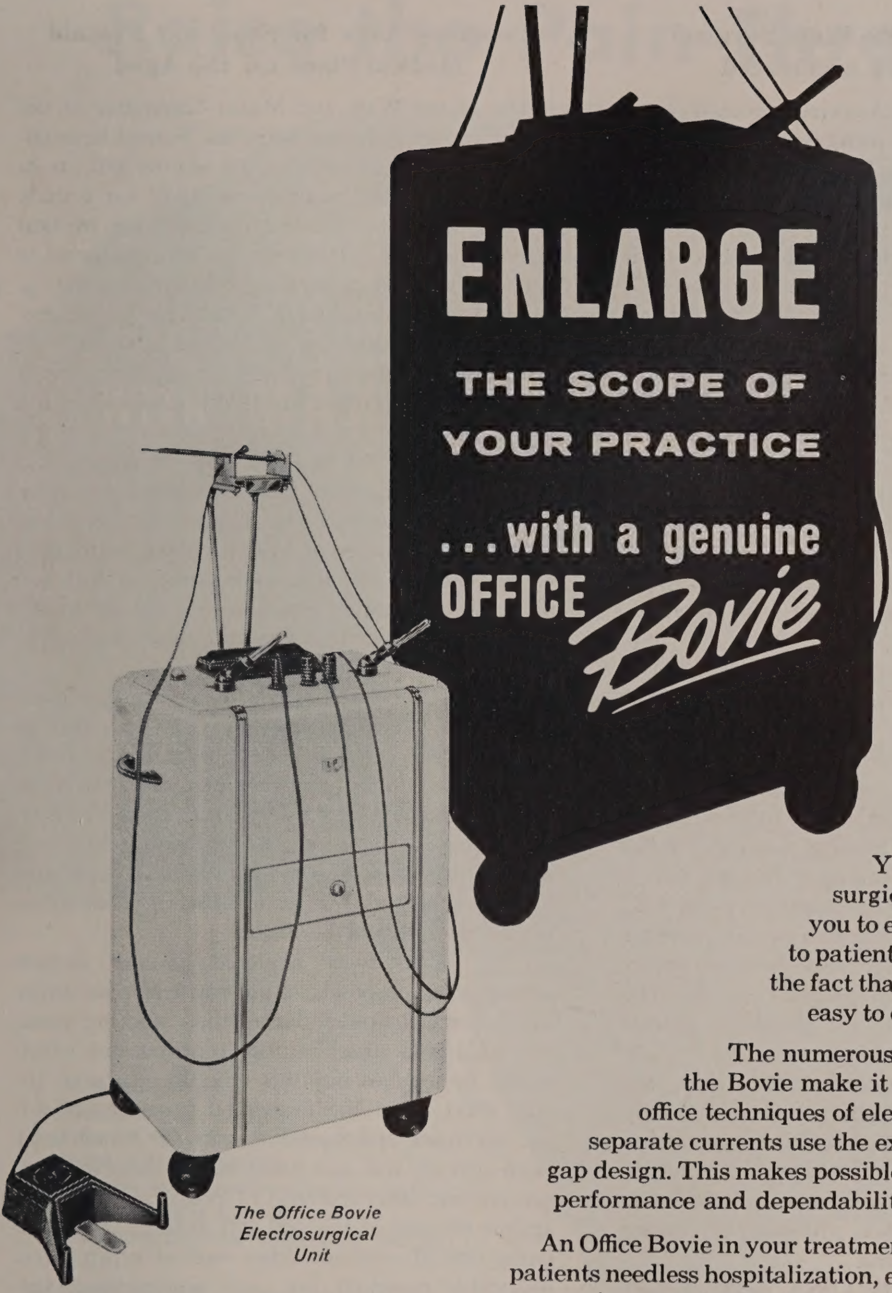

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New Officers of Ohio State Surgical Association Are Announced

The Ohio State Surgical Association recently completed a mail poll of its members and named as president-elect Dr. George N. Bates, Toledo. Dr. Stephen W. Ondash, Youngstown, was elected secretary.

Previously elected members to the board of directors are the following: Area 1, Dr. Robert G. Smith, Circleville; Area 2, Dr. Kent L. Brown, Cleveland; Area 3, Dr. E. F. Pfanner, Dayton; Area 4, Maurice F. Lieber, Canton; Area 5, Dr. William B. Faircloth, Zanesville; Area 6, Dr. Stephen A. Harris, Steubenville; Area 7, Dr. W. A. Blank, Toledo (re-elected); and Area 8, Dr. Vinton E. Siler, Cincinnati.

Cleveland has been selected as the convention city for 1959. Tentative dates are for the second week in June—exact time to be announced later. Dr. John H. Lazzari, immediate past-president, is 1959 general chairman.

At the OSSA annual meeting in Cincinnati Dr. Max M. Zinninger, professor of surgery at the University of Cincinnati, was made an honorary member. The award was made at the close of the second day's scientific sessions before some 125 surgeons from all parts of Ohio for his aid in setting up a "faculty" of leading surgeons for the 1958 program. Dr. Zinninger, though not a member of the group, volunteered to work with Dr. William Altemeier, chairman of the program committee. Dr. Altemeier also received recognition for an outstanding program, as did Dr. Clyde S. Roof, Cincinnati, the meeting's general chairman.

In presenting the honorary membership, the first since 1954, President Lazzari noted that only two other such memberships had been granted—one to Dr. Paul R. Hawley, Chicago, director of the American College of Surgeons, and the other to Dr. Harris E. Shumacher, professor of surgery at the University of Indiana.

Current president of the OSSA is Dr. Robert D. Mansfield, Cincinnati, who succeeded Dr. Lazzari.

Dr. Worden Leaving Ohio State To Take Post at UCLA Medical School

Dr. Ralph E. Worden has resigned as professor of physical medicine and director of the Rehabilitation Center, Ohio State University College of Medicine to become professor of physical medicine and chairman of the department of physical medicine and rehabilitation at the Medical School, University of California at Los Angeles. He will take over his new post about October 1.

Congress Asks for Study on Prepaid Medical Plans for the Aged

The House Ways and Means Committee of the 85th Congress, which omitted the Forand hospitalization proposal from its social security bill, in its report calls on the Secretary of HEW for a study of the various possibilities for financing medical care of the aged. The Secretary was instructed to have the study completed by February 1, 1959.

The committee told HEW to place special emphasis on the possibility of increasing social security taxes to finance purchase (through private or nonprofit organizations) of health insurance which would go into effect upon retirement.

In its instruction to HEW, the committee says it is "very much aware" of the problems in paying hospital and nursing home bills for the aged, and notes that a number of bills had been introduced on the subject, and that some witnesses had emphasized that health insurance is "out of reach" of many older people. Then the committee report comments:

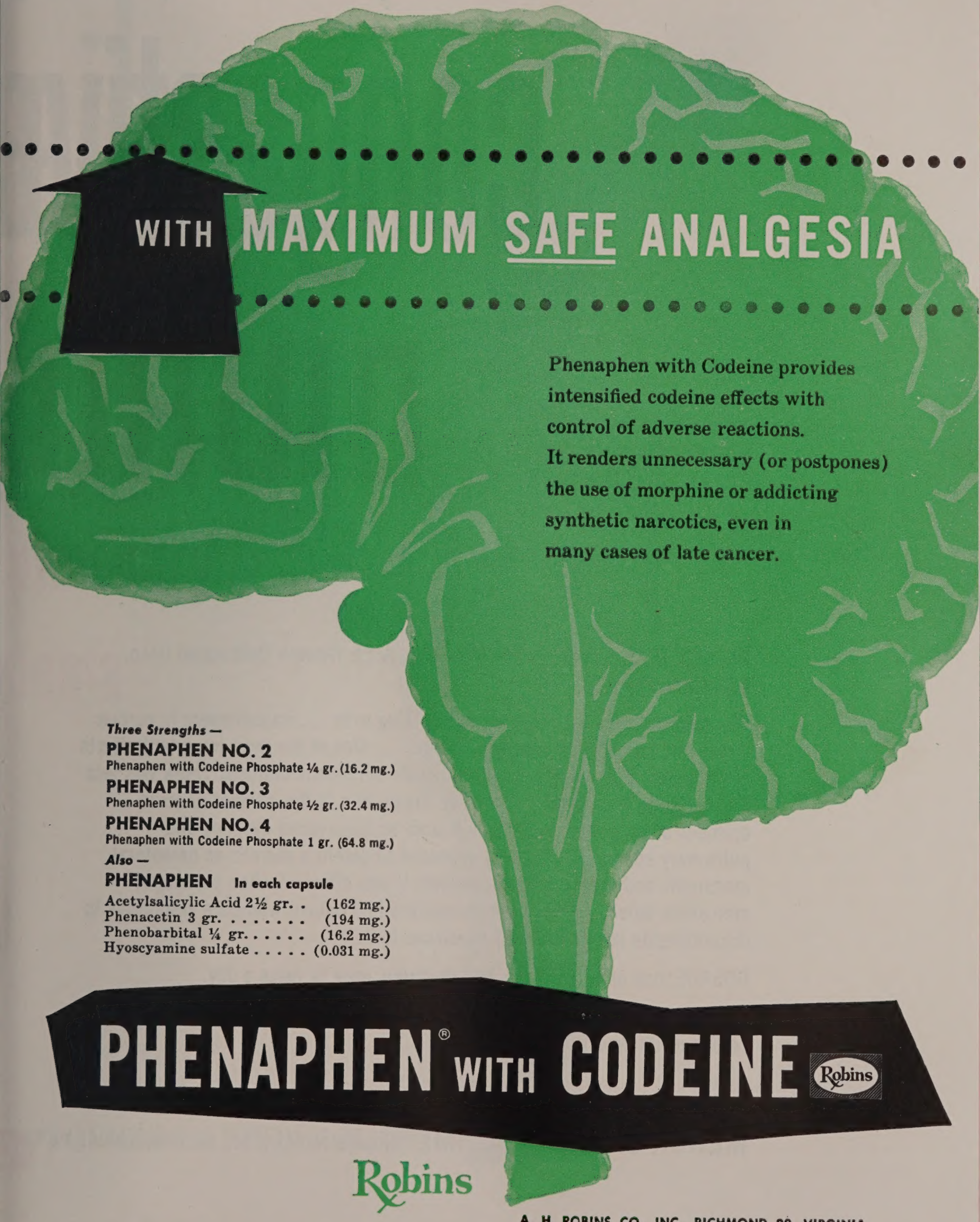
"Your committee believes, however, that more information on the practicability and the costs of providing this kind of protection through various methods should be available before it entertains any recommendation for legislation on the subject. A study of alternative ways of providing insurance against the cost of hospital and nursing home care for old-age, survivors, and disability insurance beneficiaries should be made.

"The alternatives explored should include among other proposals: a pre-payment plan under which persons would, during their working years, pay additional social security contributions which would be used to buy this type of insurance (to take effect when the individual becomes an old-age, survivors, and disability insurance beneficiary) from private and non-profit health insurance organizations; other methods of providing insurance against the cost of hospital and nursing home care under title II; and any other method which offers reasonable prospects for protecting old-age, survivors, and disability insurance beneficiaries against the cost of needed hospital and nursing home care. The study would include, for each of the several alternatives, an evaluation of (1) cost of the benefits and (2) administrative implications.

With the results of such a study available, the Congress will be in a better position to decide what legislative measures, if any, should then be taken to meet the problem."

The National Conference on Air Polution will be held November 18-20 in the Sheraton-Park Hotel, Washington, D. C.

Raise the Pain Threshold



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Phenaphen with Codeine Phosphate ¼ gr. (16.2 mg.)

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Phenaphen with Codeine Phosphate 1 gr. (64.8 mg.)

Also —

PHENAPHEN **In each capsule**

Acetylsalicylic Acid 2½ gr. .	(162 mg.)
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Phenobarbital ¼ gr.	(16.2 mg.)
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BECKER, M. C., Simon, F. and Bernstein, A.: J. Newark Beth Israel Hosp. **9**:58 (January) 1958.

"On chlorothiazide the response was striking with . . . improvement in cardiac status and loss of toxic symptomatology. . . . One of the most important effects of the potent oral diuretic was the smooth continuous diuresis. There was less fluctuation in the weight . . . marked diminution in the number of acute episodes of congestive heart failure such as paroxysmal dyspnea and pulmonary edema. . . . [DIURIL] appeared as potent a diuretic as parenteral mercurials and indeed in some patients it was effective when parenteral mercurials failed. . . . We have encountered no patient who once responsive to chlorothiazide later developed resistance to it."

DOSAGE: one or two 500 mg. tablets DIURIL once or twice a day.

SUPPLIED: 250 mg. and 500 mg. scored tablets DIURIL (chlorothiazide); bottles of 100 and 1,000.

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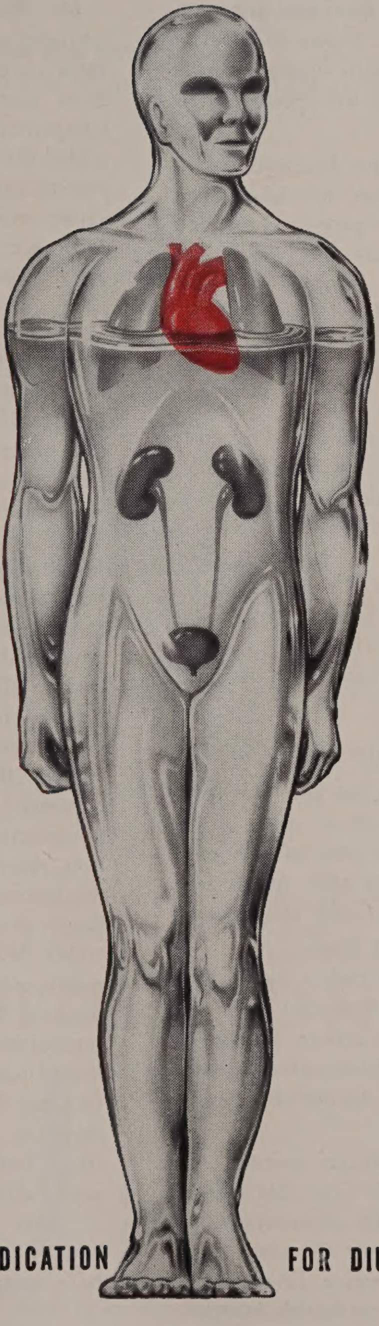

ANY INDICATION FOR DIURESIS IS AN INDICATION FOR DIURIL

Health Insurance . . .

What Do People Think of It? How Do They Use It? What Factors in Their Lives Influence Their Decisions? Survey Throws Some Light on Subject

TWO out of every five American families who are protected against the cost of illness or accident have used their health insurance in the past year to defray medical expenses, the Health Insurance Institute reported. A nationwide consumer survey of health insurance just completed, the Institute said, also shows that seven out of ten families who have such insurance have used it at some time during the period their policies were in force.

The study, conducted for the Institute by an independent research organization, was undertaken to obtain information on what people know and think about health insurance, how they use it, and also how such factors as age, income, education and place of residence are related to health insurance coverage. The survey is the first of its kind to be undertaken on a nationwide scale for insurance companies.

Results of the survey were announced recently at the annual meeting of the Health Insurance Association of America in Chicago by Albert I. Hermalin, assistant director, Division of Statistics and Research, Institute of Life Insurance, who served as consultant to the Health Insurance Institute on this project. Mr. Hermalin said the survey involved interviews with 2,000 families across the country, yielding information on more than 6,600 individuals.

About Coverage

On 53 per cent of all claims, the survey reveals, families received payment on all or most of the medical bill, while in 20 per cent of the cases payment was received for about three-quarters of the bill, and in 15 per cent of the claims, one-half of the total expenses were paid.

Some 78 per cent of the families using their health insurance expressed satisfaction with the service of the insuring organizations in paying benefits, according to the Institute survey, while 4 per cent were dissatisfied and 18 per cent had no definite opinion.

These figures, Mr. Hermalin pointed out, are consistent with the generally favorable attitude of the population toward health insurance which is revealed by the survey. Some 81 per cent of the people interviewed expressed a favorable attitude toward the idea of having health insurance for themselves, while 9 per cent were neutral in their comments and 8 per cent were unfavorable. Of the insured families, 90 per cent were favorable, and 55 per cent of the families without coverage expressed a favorable attitude.

Mr. Hermalin pointed out that the pattern of attitudes on this question is almost identical for those covered by Blue Cross-Blue Shield organizations and families protected through insurance companies. Nor is there significant variation, added the speaker, in this attitude among different income groups, or among families covered through group insurance plans and those with individual insurance policies.

It's Here To Stay

Public acceptance of health insurance is also reflected in the survey results on suggested improvements in plans or services. Some 25 per cent of the families had suggestions to make in this regard, 16 per cent gave no answer, and 59 per cent said they had no suggestions for improving health insurance plans or services.

Of the families with suggestions for improving services, 25 per cent desired more information on health insurance, while 20 per cent wanted more benefits in terms of dollars or number of days, and 14 per cent suggested lower premium costs. The responses were found to vary little by type of insuring organization.

"It would seem to be significant," Mr. Hermalin stated, "that the most frequently made suggestion expressed a desire for more information rather than a concern about prices, benefits, services, cancellation, claim service and the like. It indicates again the generally favorable feeling people have toward health insurance."

Mr. Hermalin said the survey indicates that the public does not perceive any essential difference between the health insurance provided by insurance companies and that offered by Blue Cross-Blue Shield plans. This is suggested, he added, by the fact that families who have Blue Cross-Blue Shield coverage, and those with insurance company policies, "tend to regard health insurance in almost identical ways."

"This means," he explained, "that they are equally favorable toward health insurance, they have suggestions to make with about the same

(Continued on Page 1230)

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strengthen bodies with needed protein
Through the action of l-Lysine, cereal and other low-grade protein foods are up-graded to maximum growth potential.

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with iron in the well-tolerated form of ferric pyrophosphate...plus sorbitol for enhanced absorption of both iron and B_{12}.

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WITH IRON SYRUP

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Average dosage is 1 teaspoonful daily. Available in bottles of 4 and 16 fl. oz.

Each teaspoonful (5 cc.) contains:

1-Lysine HC1	300 mg.
Vitamin B_{12} Crystalline	25 mcgm.
Thiamine HC1 (B_1)	10 mg.
Pyridoxine HC1 (B_6)	5 mg.
Ferric Pyrophosphate (Soluble)	250 mg.
Iron (as Ferric Pyrophosphate)	30 mg.
Sorbitol	3.5 Gm.

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Panalba*

(PANmycin† Phosphate plus ALBAmycin)**

your broad-spectrum antibiotic of first resort

effective against more than 30 common pathogens, even including resistant staphylococci.

Available forms:

1. Panalba Capsules, bottles of 16 and 100 capsules. Each capsule contains:

Panmycin phosphate (tetracycline phosphate complex) equivalent to tetracycline hydrochloride	250 mg.
Albamycin (as novobiocin sodium)	125 mg.

2. Panalba KM,†† Flavored Granules, 60 cc. size bottle. When sufficient water is added to fill the bottle, each teaspoonful (5 cc.) contains:

Panmycin (tetracycline) equivalent to tetracycline hydrochloride	125 mg.
Albamycin (as novobiocin calcium)	62.5 mg.
Potassium metaphosphate	100 mg.

Dosage:

Panalba Capsules
Usual adult dosage is 2 capsules q.i.d.

Panalba KM Granules
For the treatment of moderately acute infections in infants and children, the recommended dosage is 1 teaspoonful per 15 to 20 lbs. of body weight per day, administered in 2 to 4 equal doses. Severe or prolonged infections require higher doses. Dosage for adults is 2 to 4 teaspoonfuls 3 or 4 times daily, depending on the type and severity of the infection.

(Continued from Page 1226)

frequency, their suggestions are similar, they are equally informed about health insurance, and so on."

Three Out of Four

Turning to the extent of coverage, Mr. Hermalin reported that survey figures are consistent with previously published data showing that nearly three out of four American families have some form of health insurance. In 73 per cent of all families, there is some health insurance coverage and in 60 per cent of all families every family member is protected. In 27 per cent of families, no one is insured, the survey points out. It further reveals that men, women and children are covered with virtually the same frequency, with 69 per cent of the men insured, 67 per cent of the women and 66 per cent of children under eighteen so protected.

In the selection of families to be interviewed, the survey, conducted for the Health Insurance Institute by National Analysts Inc. of Philadelphia, followed a method similar to that used by the U. S. Bureau of the Census in its sample interview surveys. The Institute study required approximately eight months to complete, with each interview lasting about one and one-quarter hours.

The Health Insurance Institute is the central source of information for the nation's insurance companies serving the public through voluntary health insurance.

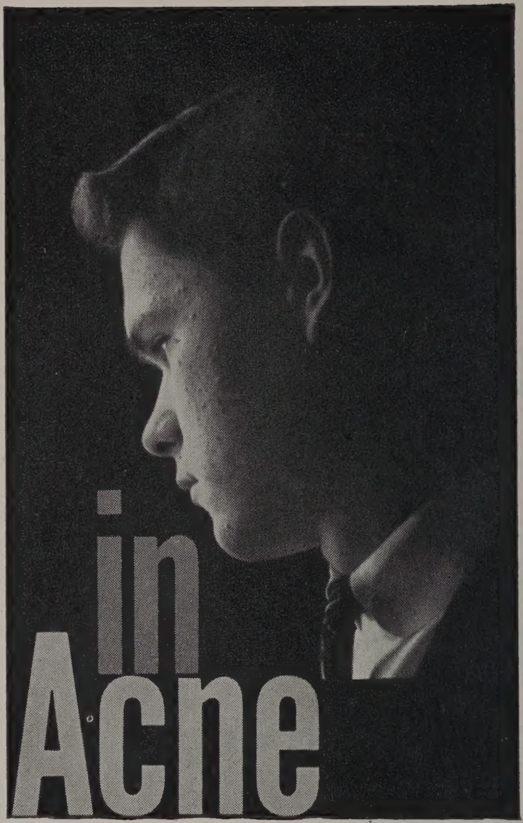
New Program To Aid Basic Medical Research

To help support the search for new medical knowledge and to increase the number of trained medical researchers, the National Fund for Medical Education has established a Medical Research Program through which contributions from united funds, community chests, voluntary health agencies and other organizations will be channelled into basic research, Fund President S. Sloan Colt has announced.

The United Community Funds and Councils of America, whose local affiliates have expressed a desire to help support broad fundamental programs of basic medical research on a national level, have agreed to support this new research program.

It is our hope, Mr. Colt said, that the voluntary health agencies which have so generously supported the categorical research into specific diseases will also support this new program.

This expansion of the National Fund's program, Mr. Colt stated, will in no way affect its campaign among corporations to obtain support for the teaching budgets of the accredited medical schools in the United States.



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pHisoHex washing added to standard treatment in acne produced results that "...far excelled...results with the many measures usually advocated."[1]

pHisoHex maintains normal skin pH, cleans and degerms better than soap. In acne, it removes oil and virtually all skin bacteria *without scrubbing.*

For best results—four to six washings a day with pHisoHex will keep the acne area "surgically" clean.

1. Hodges, F. T.: *GP* 14:86, Nov., 1956.

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Sudsing
nonalkaline
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nonirritating,
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Contains 3%
hexachlorophene.

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Monilial
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Achrostatin* V

TETRACYCLINE (PHOSPHATE-BUFFERED) AND NYSTATIN

SUPPLIED:
CAPSULES contain 250 mg. tetracycline HCl equivalent (phosphate-buffered) and 250,000 units Nystatin. ORAL SUSPENSION (cherry-mint flavored) Each 5 cc. teaspoonful contains 125 mg. tetracycline HCl equivalent (phosphate-buffered) and 125,000 units Nystatin.

DOSAGE:
Basic oral dosage (6-7 mg. per lb. body weight per day) in the average adult is 4 capsules or 8 tsp. of ACHROSTATIN V per day, equivalent to 1 Gm. of ACHROMYCIN V.

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Combines ACHROMYCIN V with NYSTATIN

ACHROSTATIN V combines ACHROMYCIN† V...the new rapid-acting oral form of ACHROMYCIN† Tetracycline...noted for its outstanding effectiveness against more than 50 different infections...and NYSTATIN...the antifungal specific. ACHROSTATIN V provides particularly effective therapy for those patients who are prone to monilial overgrowth during a protracted course of antibiotic treatment.

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Activities of Woman's Auxiliary . . .

CHAIRMAN PUBLICITY COMMITTEE—Mrs. W. J. Horger, 1100 Ohio Ave., East Liverpool, Ohio
(See Page 1121 for roster of officers.)

CUYAHOGA COUNTY

The Cuyahoga Medical Auxiliary has been active during the summer months. In the May meeting the following officers were installed: Mrs. Fred R. Rittinger, president; Mrs. Frank L. Meany, president-elect; Mrs. George Tischler, vice-president; Mrs. Thomas Manning, recording secretary; Mrs. Edward Marshall, corresponding secretary; Mrs. Joseph Crowley, treasurer; Mrs. John H. Atkins, assistant treasurer. Directors—Mrs. John Budd, Mrs. James Gavin, Mrs. William Nosik, Mrs. Myron Perlich, Mrs. George Petznick, Mrs. Kenneth Potter.

The Auxiliaries' first bowling league of 20 members closed with a luncheon at Caminati's. Mrs. Charles Reinacher, president of the league, awarded trophies to the leading team of Mrs. George Lockhart, Mrs. W. W. Faller, Mrs. Vincent Kaval, and Mrs. Roscoe Kennedy.

The league will bowl again in September with membership increased to 40 in East Cleveland and 20 in West Cleveland.

Auxiliary members continued their job of good public relations in the community. Mrs. George Tischler served as hospitality chairman for United Appeal at the meeting to help the Red Cross and Community Chest and plan for the Fall Campaign.

On May 24 the Academy of Medicine sponsored a group of 80 High School students through the medical school. The Auxiliary members served the boys lunch.

TRUMBULL COUNTY

Members of the Auxiliary to the Trumbull County Medical Society have for many years given of their time and money to aid the Student nurses at Trumbull Memorial Hospital in Warren.

This year's Student Nurse Committee had a picnic for all the student nurses on July 31. The picnic was held at the home of Mrs. T. P. Berry at Kinsman. Mrs. John Caldwell was co-chairman. Other members of the committee furnished transportation.

Neurosurgeon Goes to Los Angeles

Dr. Kenneth H. Abbott, former practicing physician in Columbus and assistant clinical professor of neurosurgery at Ohio State University, is now in Los Angeles where he is professor of neurological surgery at the College of Medical Evangelists, Los Angeles Section.

New Joint Council on Health Care of Aged Names Executive Secretary

The Joint Council to Improve the Health Care of the Aged has been named Howard I. Wells, Jr., of Chicago as its executive secretary, Dr. Edwin L. Crosby, the Council's interim secretary, reported. Dr. Crosby is also director of the American Hospital Association.

The establishment of the Joint Council was announced on April 8 by the four founding organizations—the American Dental Association, the American Hospital Association, the American Medical Association and the American Nursing Home Association.

Objectives of the Council were announced as "(1) to identify and analyze the health needs of the aged; (2) to appraise available health resources for the aged; and (3) to develop programs to foster the best possible health care for the aged regardless of their economic status."

Offices of the Council have been set up at 139 N. Clark St., Chicago.

Mr. Wells takes over his new post after being executive secretary of the American Association for Maternal and Infant Health since February 12, 1954. He took his baccalaureate at Northwestern University and did graduate study in social welfare administration at the University of Copenhagen in Denmark.

He has held positions with the Community Fund of Chicago, the Federal Council of the Churches of Christ in America, the American City Bureau, and the Illinois Division of the American Cancer Society.

University of Buffalo Announces Series of Fall Courses

The University of Buffalo School of Medicine has announced several fall postgraduate courses. Details may be obtained by writing the Department of Postgraduate Education, 3435 Main St., Buffalo 14, N. Y. The following short courses have been announced: September 17-18, "Use and Interpretation of Diagnostic X-Ray"; October 1-2, "Arthritis"; October 15-16, "Modern Laboratory Procedures in Clinical Practice"; October 22-23; "Recent Advances in Chest Diseases"; October 29-30, "Psychiatric Problems in General Practice."

Chest Physicians Certified

The American College of Chest Physicians awarded Fellowship Certificates to two Ohio physicians at its recent 24th annual meeting in San Francisco. They are Dr. Neil C. Andrews, Columbus, and Dr. Bernard L. Brofman, Cleveland.

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with a
plus factor
in treating
the overweight

In addition to dulling the appetite, elevating the mood, and easing anxiety, Bifran tablets contain the plus factor, Cholan DH® (dehydrocholic acid, Maltbie). This hydrocholeretic maintains a normal flow of bile, thus avoiding the physiological consequences of low fat intake in the usual dietary program.

Prescribe Bifran tablets for your overweight patients.

Each Bifran tablet contains 5 mg. methamphetamine hydrochloride, 200 mg. dehydrocholic acid (Maltbie), and 15 mg. pentobarbital.

Supplied: Bottles of 100, 500, 1,000.

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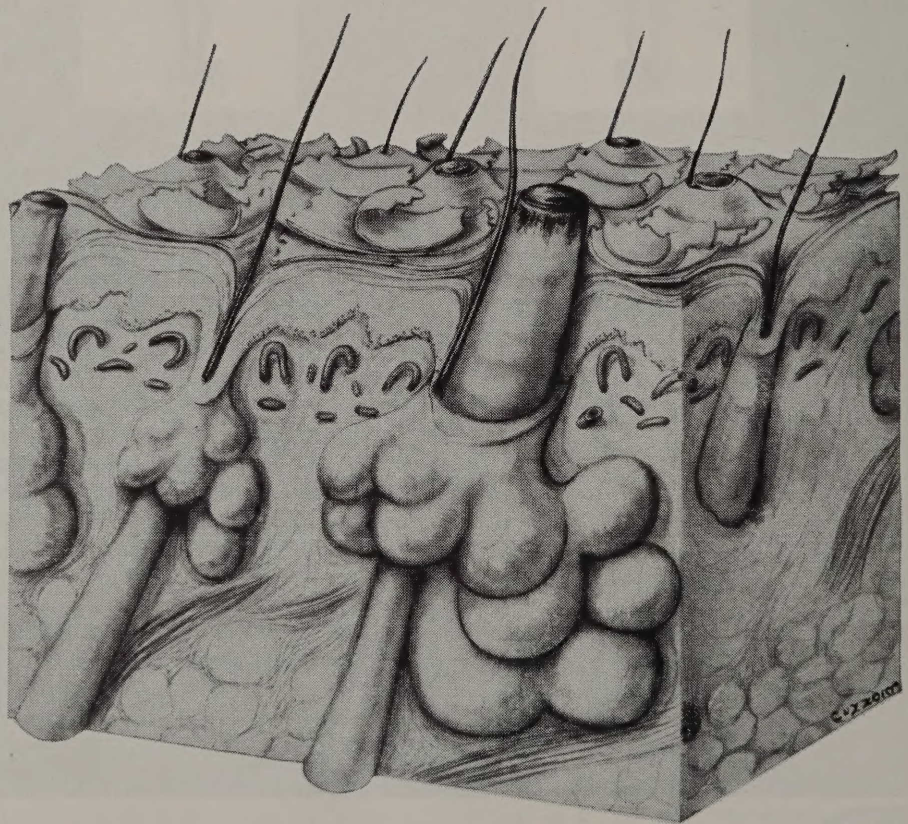
cut treatment time in half
using half the amount of vitamin A

in **acne,**

eczemas, dry scaly skin

aquasol A

the original aqueous, natural
high-potency vitamin A in capsule form



hyperkeratosis, desquamation and comedone formation with resultant follicular plugging

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Aquasol A capsules are aqueous

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Aquasol A capsules contain natural vitamin A for faster, better utilization.

Natural vitamin A provides all known and fully utilizable physiologically active isomers of vitamin A — as compared with synthetic vitamin A which affords only one isomer, an isomer requiring conversion in the body before it can be utilized in certain enzyme processes.

Vitamin A has become an integral part of therapy in acne, chronic eczemas, excessively dry skin and other hyperkeratotic lesions. Why not use more effective, convenient Aquasol A capsules. Special processing of the natural vitamin A removes potential allergenic non-vitamin materials.

three separate high potencies of

AQUASOL A CAPSULES

(water-solubilized natural vitamin A)
. . . per capsule:

25,000 U.S.P. units

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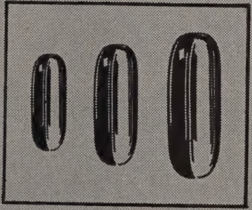
100,000 U.S.P. units

bottles of 100, 500 and 1000 capsules



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A hospital for the treatment of Psychiatric Disorders. *Booklet available on request.*

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COMBINES: Traditional components for relief of the annoying symptoms of early upper respiratory infections . . .

PLUS: Protection against bacterial complications often associated with such conditions.

TABLETS (sugar coated)
Each contains:

ACHROMYCIN* Tetracycline	125 mg.
Phenacetin	120 mg.
Caffeine	30 mg.
Salicylamide	150 mg.
Chlorothen Citrate	25 mg.

Bottles of 24 and 100.

SYRUP (lemon-lime flavored, caffeine-free)
Each 5 cc. teaspoonful contains:

ACHROMYCIN* Tetracycline equivalent to Tetracycline HCl	125 mg.
Phenacetin	120 mg.
Salicylamide	150 mg.
Ascorbic Acid (C)	25 mg.
Pyrilamine Maleate	15 mg.
Methylparaben	4 mg.
Propylparaben	1 mg.

Bottle of 4 fl. oz.

Adult dosage for ACHROCIDIN Tablets and new caffeine-free Syrup is two tablets or teaspoonfuls of syrup three or four times daily. Dosage for children adjusted according to age and weight.
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ESTABLISHED 1873

A Private Psychiatric Hospital Offering Modern Diagnostic and Treatment Procedures

- Equipped to provide all modern and accepted methods of treatment.
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- Rest Cottage, a separate department for mild neurotic problems and the convalescent.

OUT-PATIENT DEPARTMENT LOCATED IN A COMPLETELY NEW BUILDING

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CHARLES W. MOCKBEE, M. D. . . . Associate Director
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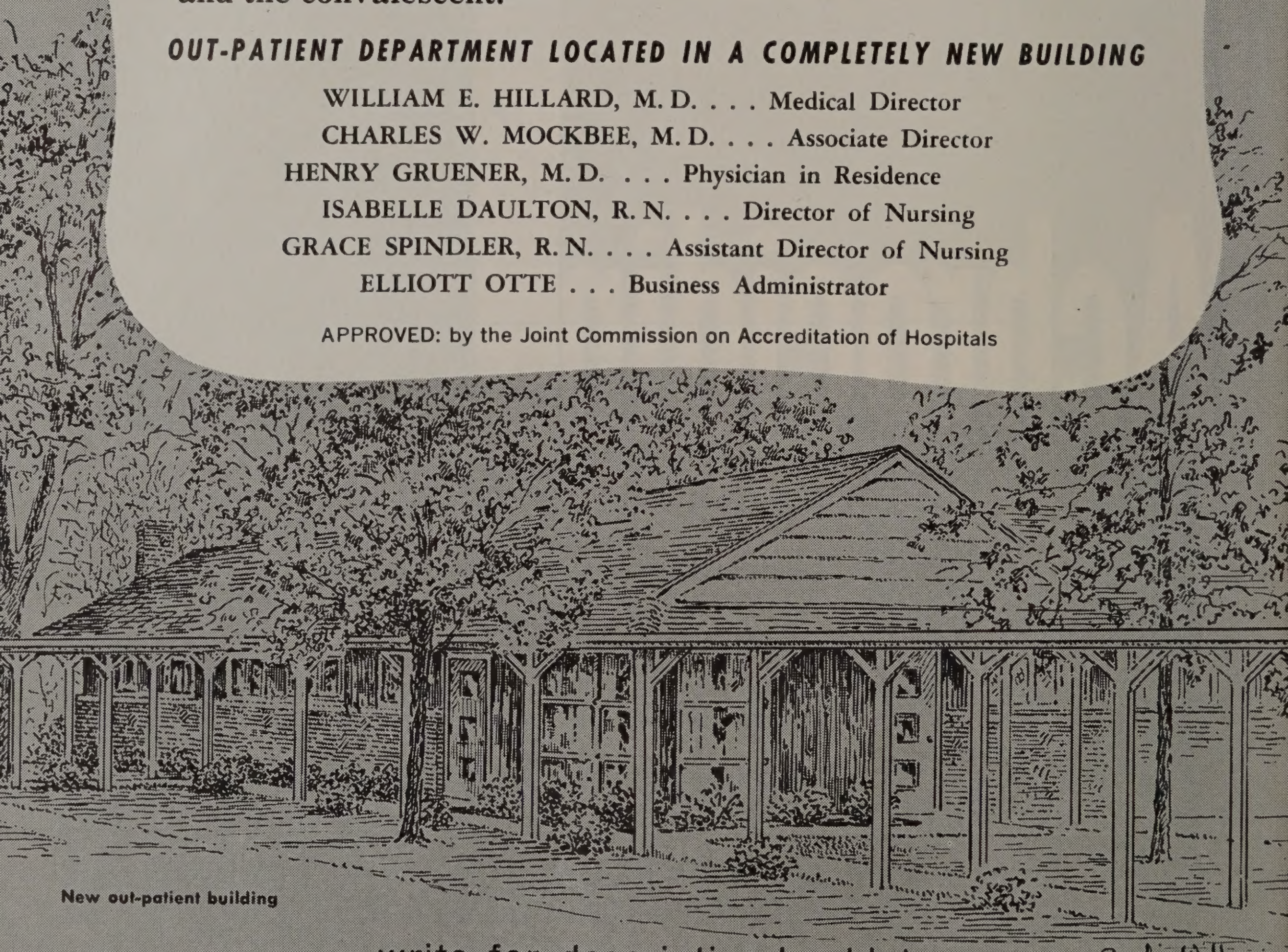
ISABELLE DAULTON, R. N. . . . Director of Nursing
GRACE SPINDLER, R. N. . . . Assistant Director of Nursing
ELLIOTT OTTE . . . Business Administrator

APPROVED: by the Joint Commission on Accreditation of Hospitals



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▲'Deprol'▲†

Clinically confirmed
in over 1,200
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Deprol ► acts promptly to control depression *without* stimulation
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Deprol is unlike amine-oxidase inhibitors

- ► does not adversely affect blood pressure or sexual function
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Deprol is unlike central nervous stimulants

- ► does not cause insomnia
- ► produces no amphetamine-like jitteriness
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- ► has no depression-producing aftereffects
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Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: Each tablet contains 400 mg. meprobamate and 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl).

Supplied: Bottles of 50 scored tablets.

1. Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. **166**:1019, March 1, 1958. 2. Current personal communications; in the files of Wallace Laboratories.

†TRADE-MARK
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Literature and samples on request WALLACE LABORATORIES, *New Brunswick, N. J.*

For Speedier Return to Normal Nutrition

Meat...

in Inflammatory Conditions of the Colon

The physiologic depletion accompanying acute infectious and inflammatory conditions of the bowel makes replacement therapy the key to nutritional rehabilitation.

In addition to the loss of important electrolytes, such as potassium and sodium, large amounts of protein are lost in the fluid, blood and exudate from the bowel. In the acute state of such affections, utilization of what protein can be ingested is further affected by increased protein catabolism and by impairment of certain hepatic functions.

Dietary rehabilitation must be carried out within the framework of a diet restricted in fiber and in irritating substances. Foods allowed must be easily digested and appetizingly and attractively prepared to encourage eating.

Tender lean meats—finely ground in the initial diet and later served in a wide variety of appealing ways—can be an important source of the protein and minerals required by the convalescing patient.

Meat fits admirably into the requirements of the permitted diet not only because of its taste, digestibility, and physical characteristics, but also because of its contribution of high quality protein, the minerals potassium, iron, phosphorous, sodium, and magnesium, and all the known B vitamins.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

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AMPLUS®
for sound obesity management
dextro-amphetamine plus vitamins and minerals

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STIMAVITE®
stimulates appetite and growth
vitamins B_1, B_6, B_{12}, C and L-lysine

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OBRON®
a nutritional buildup for the OB patient

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when anemia complicates pregnancy

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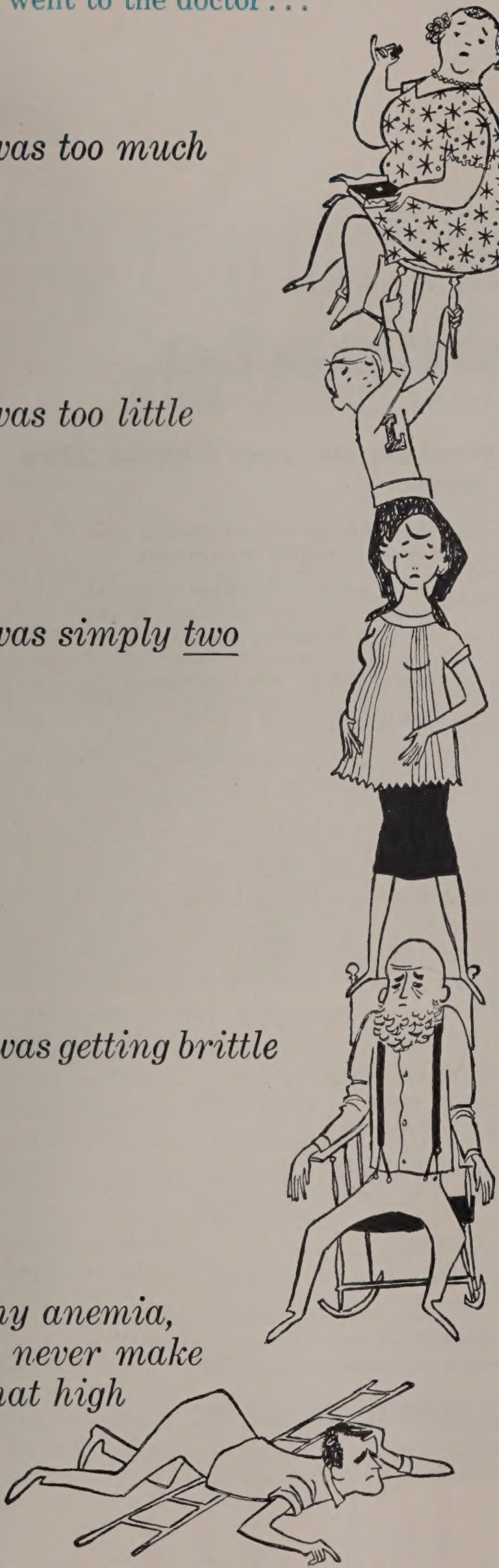
With my anemia,
I could never make
it up that high

ROETINIC®
one capsule a day, for all treatable anemias

HEPTUNA® PLUS
when more than a hematinic is indicated



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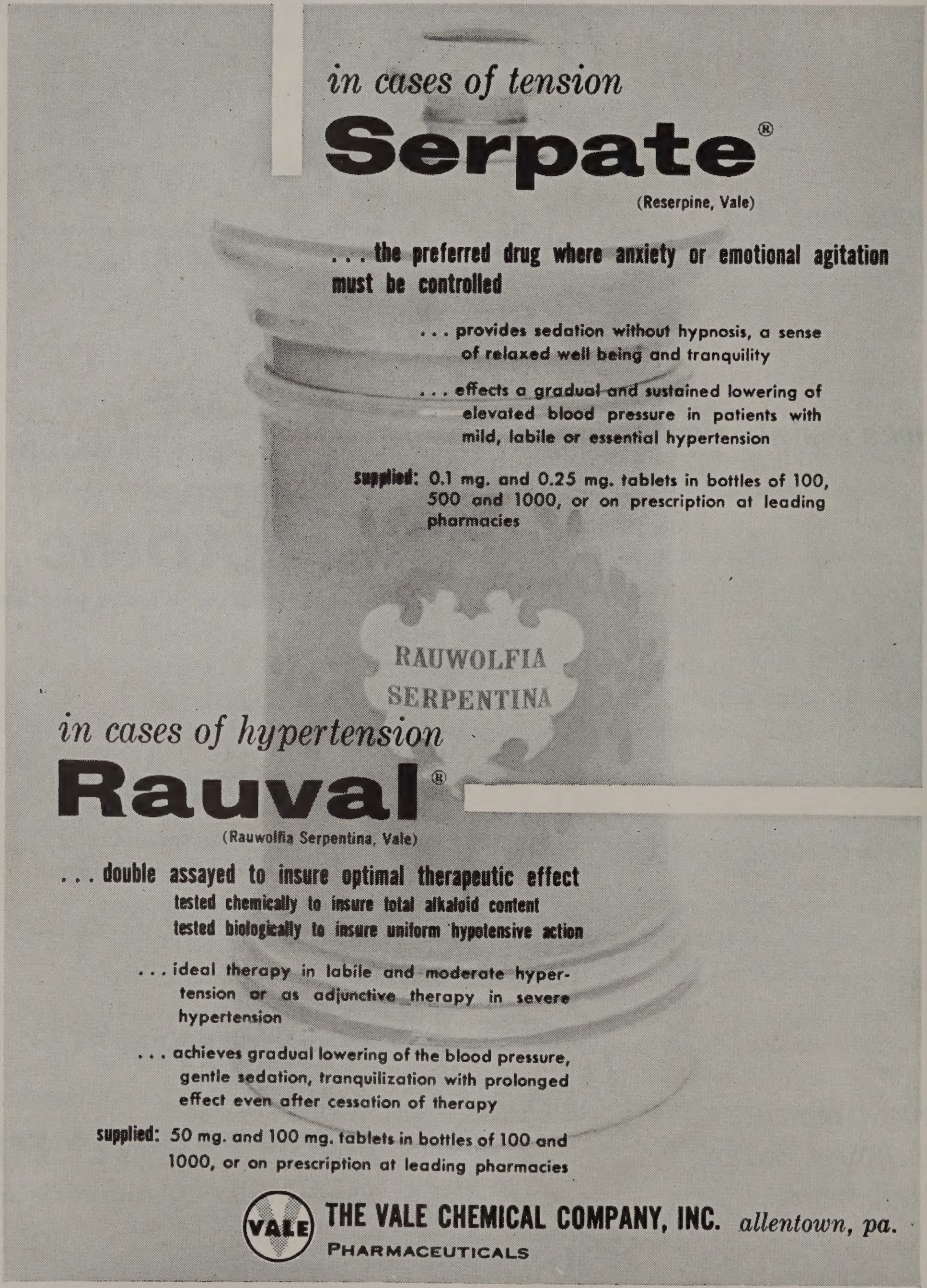

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*Morrison, L. F.: Arch. Otolaryng. 59:48-53 (Jan.) 1954.

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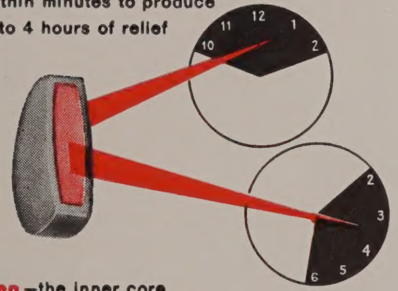

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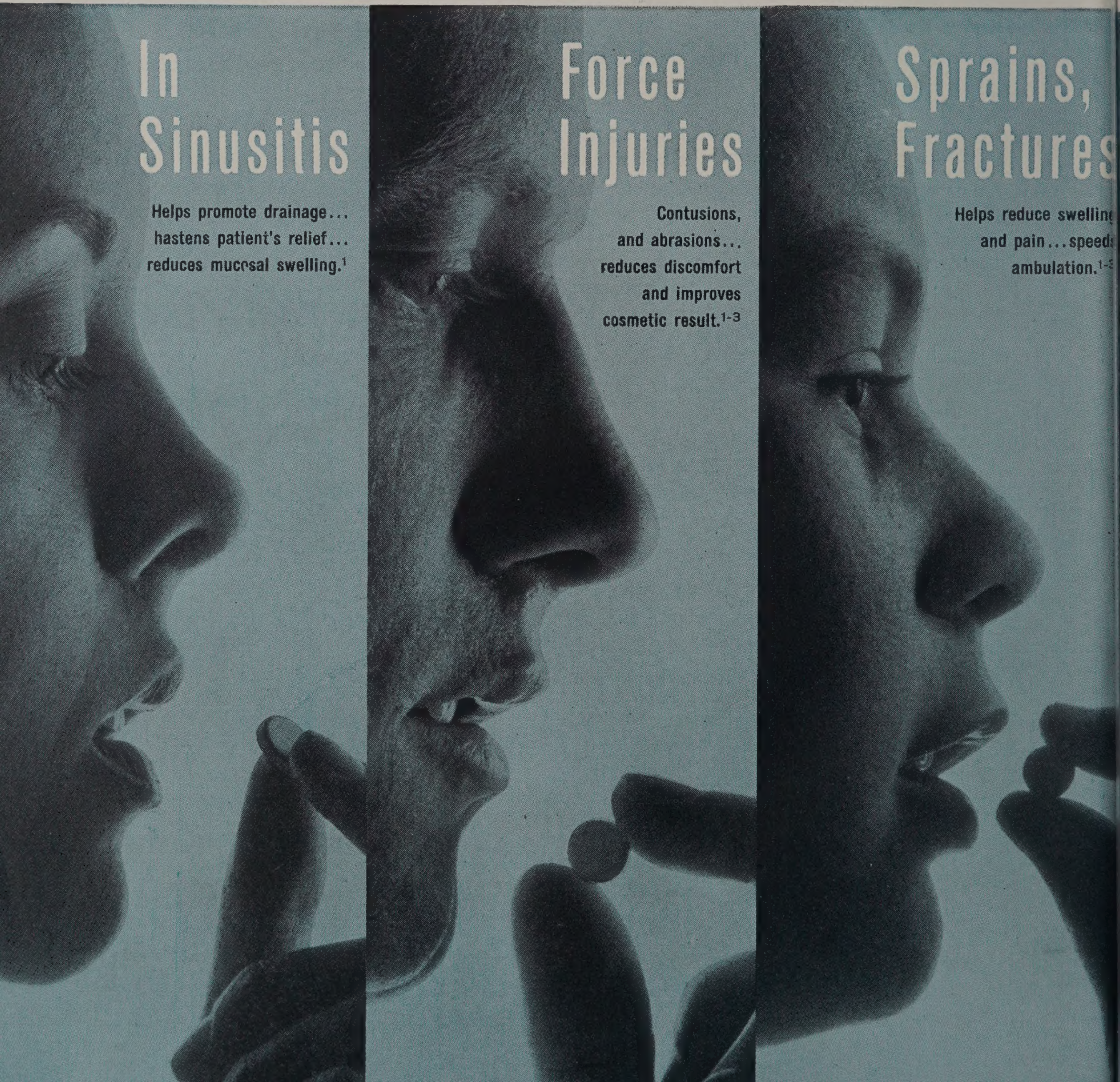

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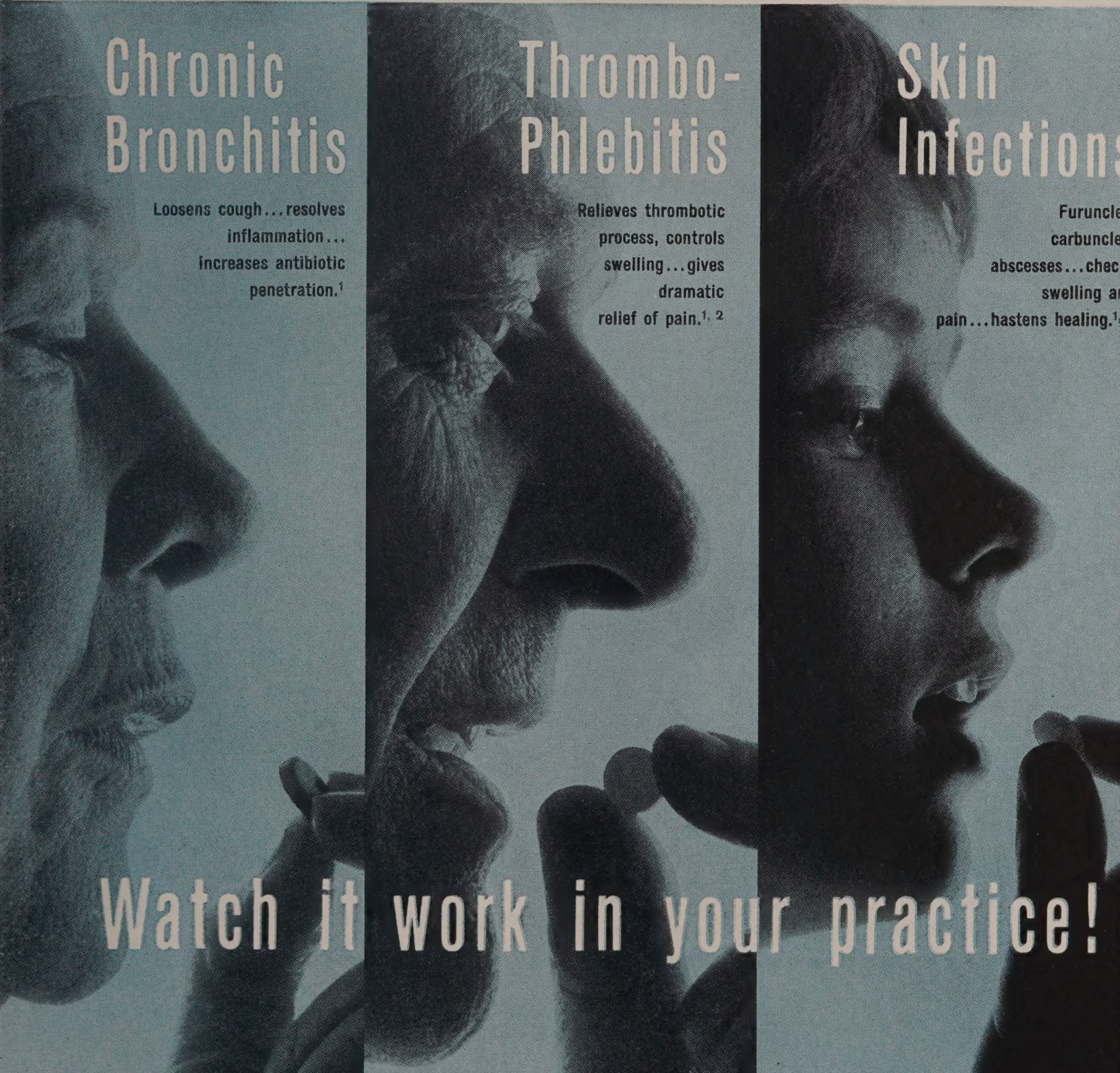
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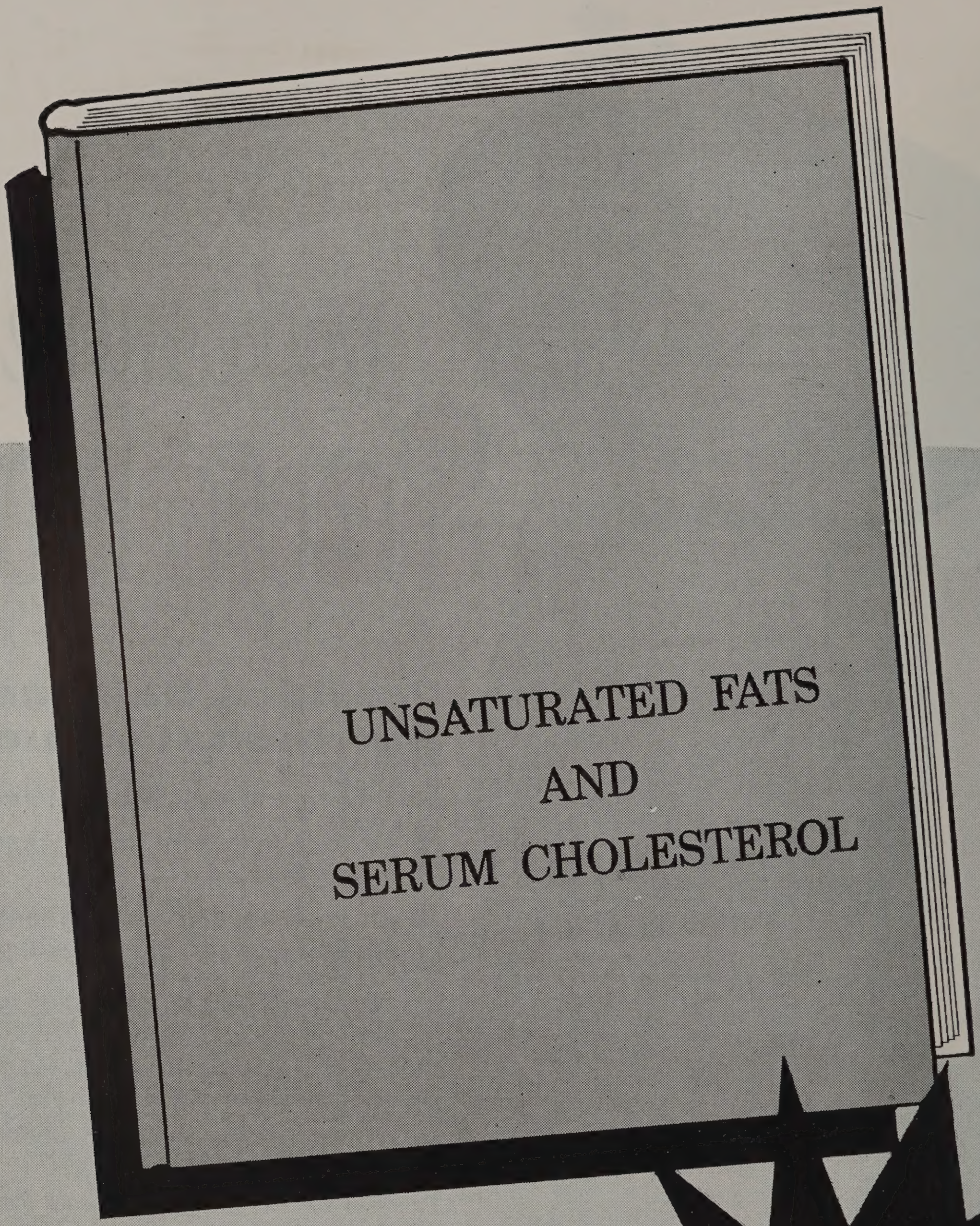
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COMING MEETINGS

Ohio State Medical Association, 1959 Annual **Meeting,** April 21-24, Columbus.

American Medical Association, Clinical Session, December 2-5, Minneapolis, Minn.

American Association of Medical Assistants, Palmer House, Chicago, October 31-November 2.

Columbus Academy of Medicine, Clinic Day, Columbus, November 1.

Eighth Councilor District, Annual Medical Meeting, Zanesville Country Club, Zanesville, October 2.

Industrial Medical Association of Pittsburgh, Sheraton-Mayflower Hotel, Akron, September 19.

Mississippi Valley Trudeau Society, Dayton, October 17.

Montgomery County Medical Society Founders' Day, Biltmore Hotel, Dayton, October 3.

National Institute of Arthritis and Metabolic Diseases, Session on Rheumatic Diseases, Ohio State University Campus, Columbus, October 19.

Ohio Academy of General Practice, Annual Scientific Assembly, October 1-2, Toledo.

Sixth Councilor District, Postgraduate Day, October 22, Akron.

University of Cincinnati College of Medicine, Postgraduate Course in Heart Disease, Cincinnati, September 3-6.

WHAT TO WRITE FOR

Some booklets, pamphlets and other published material available for the asking or at nominal expense and suitable for the physician's office, library or waiting room, or for his personal information.

Licensed Rest Homes in Ohio. Division of Social Administration, Ohio Department of Public Welfare, has printed a new list of licensed rest homes. Write Division of Social Administration, Oak and Ninth Streets, Columbus, Ohio.

Healthful School Living. This joint AMA-NEA publication concerns school environment and completes a trilogy, the two former being health education and school health services. ($5) Write AMA Bureau of Health Education, 535 North Dearborn Street, Chicago, Ill.

Mental Health: A Ford Foundation Report. This pamphlet presents a general, nontechnical account of the Ford Foundation's work in the field of mental health. Write Ford Foundation, Office of Reports, 477 Madison Avenue, New York 22, New York.

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Rates: 50 cents per line. Minimum charge of $1.00 for each insertion. Prices cover the cost of remailing answers. Forms close 15th of the month preceding publication. To assure prompt delivery, when replying to an advertisement over a *Journal* box number, address letters as follows: Box (insert number), c/o The Ohio State Medical Journal, 79 East State St., Columbus 15, Ohio.

Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 79 E. State St., Columbus 15. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

NEW MEDICAL CENTER opening within 30 days in Solon, Ohio, fastest growing industrial area in the State. Desirable location for G. P., Pediatrician, Ophthalmologist, Radiologist and Surgeon. Contact Norton Norr, 2177 S. Taylor Rd., University Heights 18, Ohio. FA 1-0190.

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Nursing in Disaster

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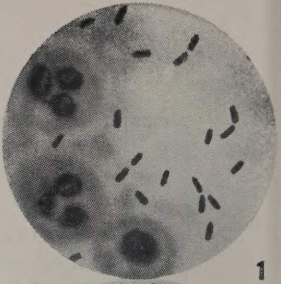
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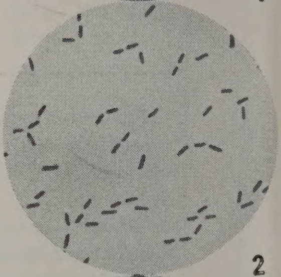
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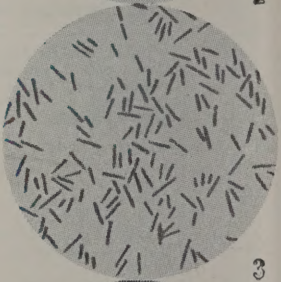
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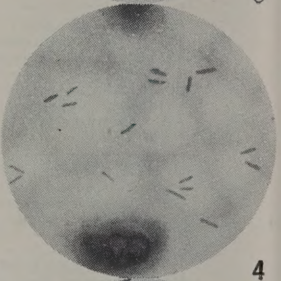
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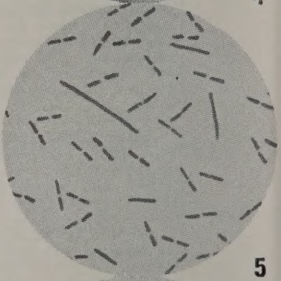
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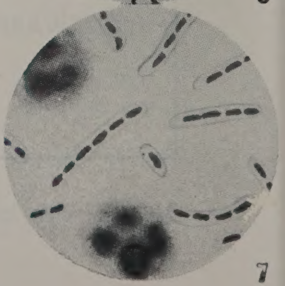
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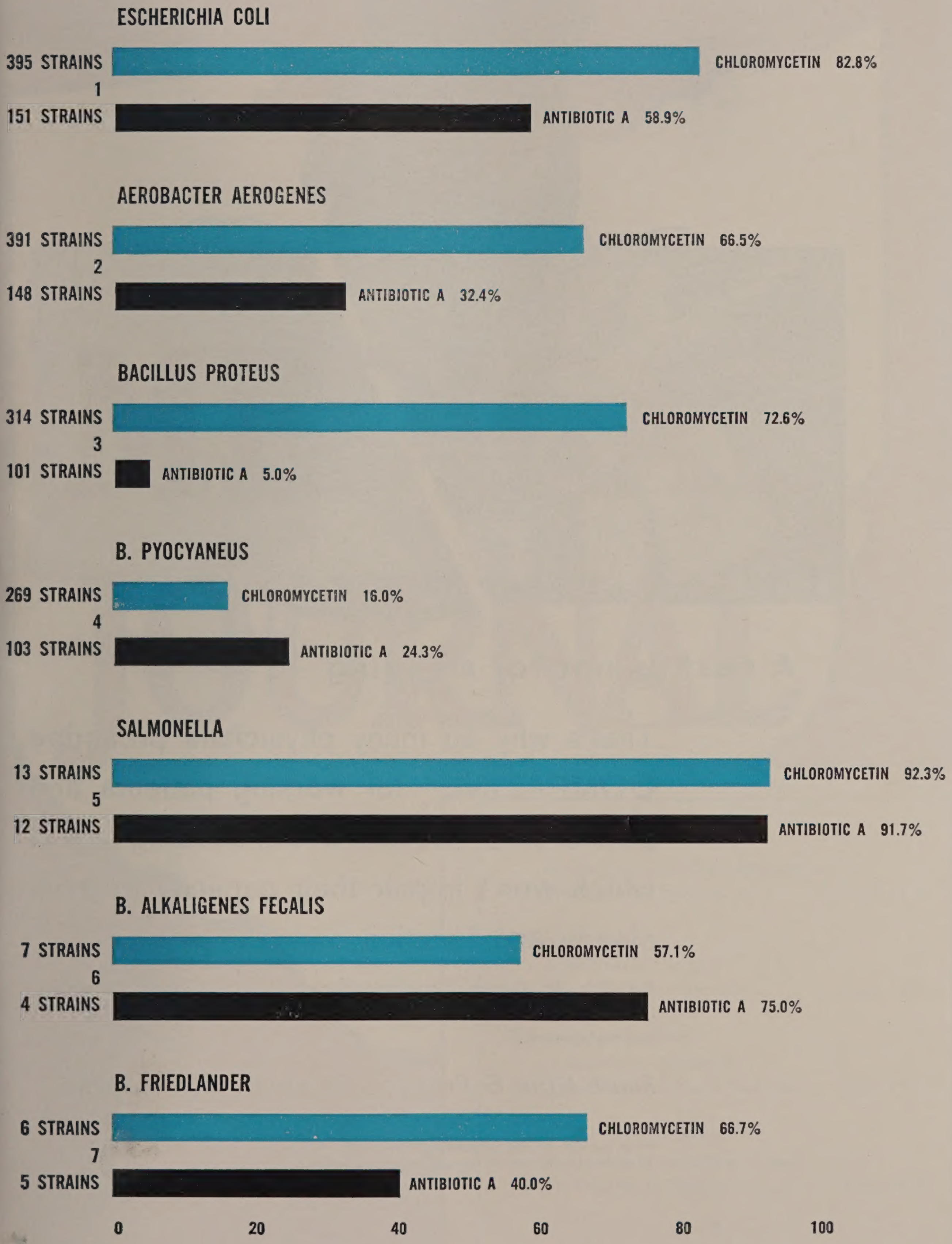

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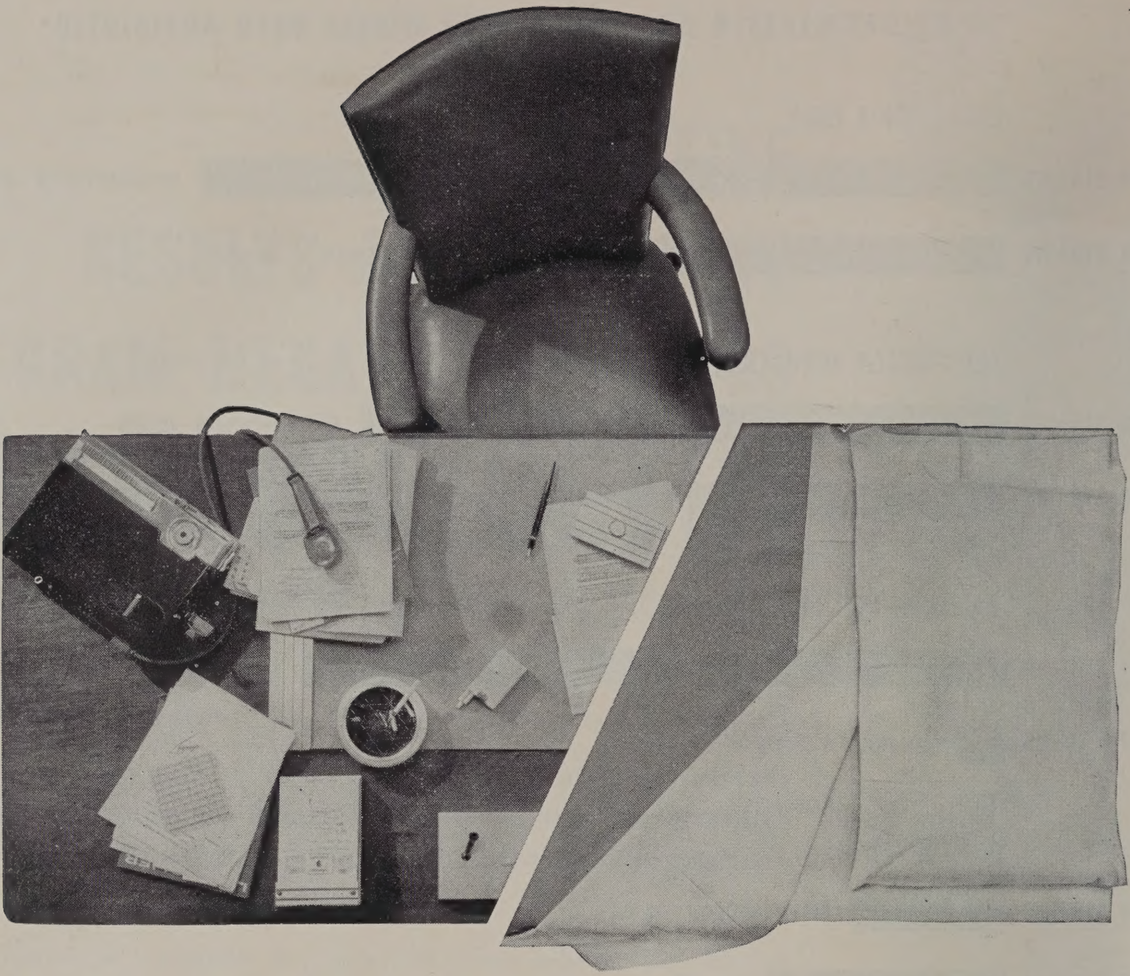

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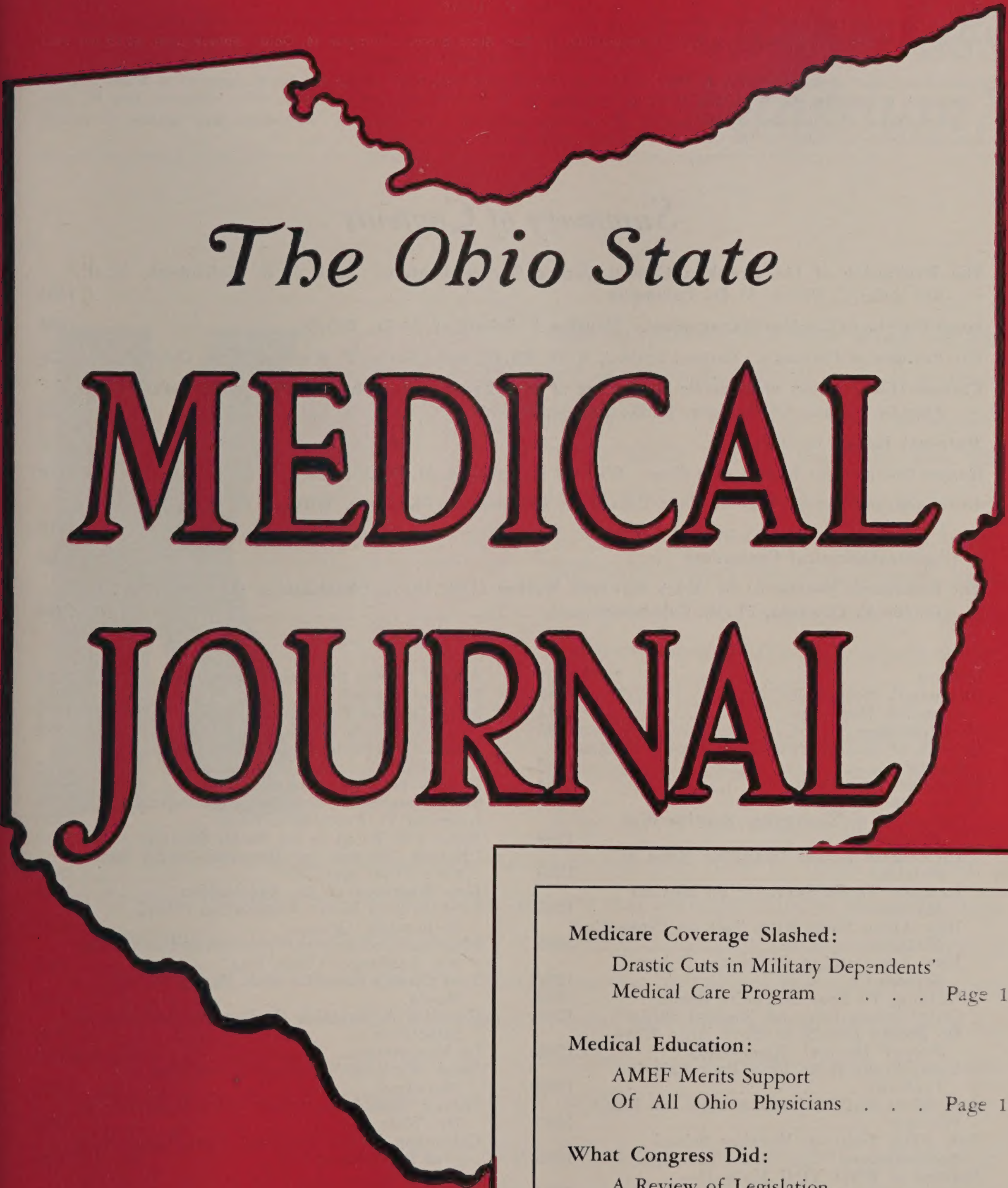

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The Ohio State Medical Journal

Vol. 54 October, 1958 No. 10

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why all the fuss over potassium?

K?

Many physicians will recall when safe but potent organomercurials were first introduced. At the time there was considerable worry about possible potassium loss. Patients were instructed to take foods rich in this mineral, and not infrequently potassium supplements also were advised. After enough experience was gained, it became evident that only the exceptional case could lose enough potassium to be concerned about. And with oral organomercurial diuretics this was practically never a problem.

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- those on corticoids
- those who developed moniliasis on previous broad-spectrum therapy
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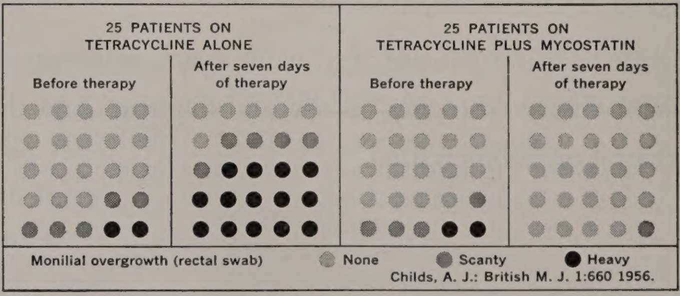

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Each Bifran tablet contains 5 mg. methamphetamine hydrochloride, 200 mg. dehydrocholic acid (Maltbie), and 15 mg. pentobarbital.

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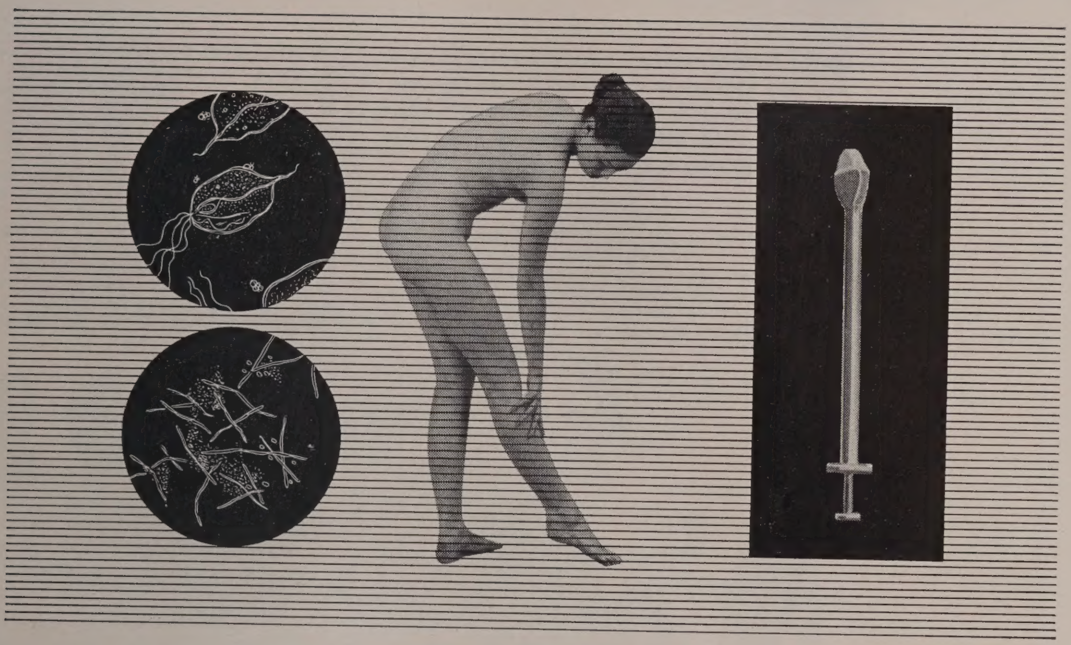

Floraquin®

Destroys Common Vaginal Pathogens; Rebuilds Normal Bacterial Barrier

Whenever a woman complains of vaginal discharge with pruritus, a trichomonal infection[1] must be suspected. Moniliasis, the second most frequent cause[2] of leukorrhea, often occurs[3] in conjunction with diabetes mellitus, pregnancy and estrogen or broad spectrum antibiotic therapy. Commonly used douches wash away normal acid secretions and protective Döderlein bacilli, thus tending to aggravate the problem.

Floraquin, containing Diodoquin® (diiodohydroxyquin, U.S.P.), eliminates infection and provides boric acid and sugar to restore the acidic pH which favors replacement of pathogens by normal Döderlein bacilli. The danger of recurrence is thus minimized.

Pitt reports[2] consistently good results after daily vaginal insufflation of Floraquin powder for three to five days, followed by acid douches and the daily insertion of Floraquin vaginal tablets throughout one or two menstrual cycles.

Intravaginal Applicator for Improved Treatment of Vaginitis—

This smooth, unbreakable, plastic plunger device is designed for simplified insertion of Floraquin tablets by the patient; it places tablets in the fornices and thus assures coating of the entire vaginal mucosa as the tablets disintegrate. A Floraquin applicator is supplied with each box of 50 tablets.

G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

---

[1] Davis, C. H.: Trichomonas Vaginalis Infections: A Clinical and Experimental Study, J.A.M.A. *157:*126 (Jan. 8) 1955.

[2] Pitt, M. B.: Leukorrhea, Causes and Management, J.M.A. Alabama *25:*182 (Feb.) 1956.

[3] Lang, W. R.: Recent Advances in Vaginitis, Philadelphia Med. *51:*1494 (June 15) 1956.

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Joint inflammation and muscle spasm are the two elements most responsible for disability in rheumatic-arthritic disorders — and MEPROLONE is the one agent that treats both.

MEPROLONE suppresses the inflammatory process and simultaneously relieves aching and stiffness caused by muscle spasm, to provide greater therapeutic benefits and a shorter rehabilitation period than any single antirheumatic-antiarthritic agent.

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The Physician's Bookshelf

By JONATHAN FORMAN, M.D.

The Student-Physician; Introductory Studies in the Sociology of Medical Education, edited by Robert K. Merton, George G. Reader, M. D., and Patricia L. Kendall. ($5.00, Published for the Commonwealth Fund by the *Harvard University Press, Cambridge 38, Mass.)* This is a pioneer study of the sociological and the psychological problems inherent in the development of young doctors and examines the fundamental, personal questions which concern the medical students and those in charge of medical education and attempts to outline the urgency and desires that lead young men to study medicine.

Essays in Metabolism, edited by Louis G. Welt, M. D. ($6.50, *Little, Brown and Company, Boston 5, Mass.)* This is the John Punnett Peters number of the *Yale Journal of Biology and Medicine.* It is an unusual festschrift. Rather than a miscellaneous collection of unimportant papers dug out of dusty files by each and every former student, this is a collection of essays prepared especially for this volume which cover in a general area of clinical biochemistry half a dozen subjects which Dr. Peters made his own. This belongs in the library of everyone and every institution that is interested in biochemistry.

Understanding Your Patient, by Samuel Liebman, M. D. ($5.00, *J. B. Lippincott Company, Philadelphia 5, Pa.)* It is the third in a series of aims at helping the medical practitioner understand his patients. Recent studies indicate that as high as 80 per cent of the patients appearing for medical advice have shown significant psychological factors in the genesis of their complaint. This book devotes itself to putting emphasis on the examination and treatment of individuals from this vital point of view.

In Search of Man, by André Missenard. ($5.95, *Hawthorn Books, Inc., New York 11, N. Y.)* This French scientist and Alexis Carrel, collaborator, in the foundation for the study of human problems present for the first time their studies of the influence of heredity and environment and the effects of spiritual forces for the formation of man's personality and the society in which he exists. Those who profited by Dr. Carrel's **Man the Unknown** will enjoy and profit by this book.

The Chemical Dynamics of Bone Mineral, by William Neuman and Margaret W. Neuman. ($5.00, *University of Chicago Press, Chicago 37, Illinois.)* This book is an up-to-date summary on bone mineral which resolves the old dilemma of blood bone equilibrium. At last this strange paradox finds its logical resolution in the summary of current information on how these physiological processes are controlled.

General Diagnosis and Therapy of Skin Diseases, by Herman Werner Siemnes, M. D., translated by Curt Wiener, M. D. ($10.00, 375 Illustrations. *University of Chicago Press, Chicago 37, Illinois.)* The author presents basic dermatological principles clearly and succinctly and illustrates these principles with hundreds of close-up photographs taken under his direction at the University of Leiden in Holland.

Practical Use of the Office Laboratory and X-Ray Including the Electrocardiograph, by Paul Williamson, M. D. ($10.75, *The C. V. Mosby Company, St. Louis 3, Mo.)* This book is designed to make possible the maximum benefit of the office laboratory thus greatly increasing the scope of office practice and adding to diagnostic accuracy. It is for the home-trained technician with a minimum of equipment.

Health Through Nutrition, by Lelord Kordel, Sc. D. ($3.50, *World Publishing Company, Cleveland 2, Ohio.)* The author, a well-known lecturer on nutrition, and a student of biochemistry, gives us popular instruction on how to live long and like it, covering both our mental and physical health as it is related to our nutrition.

The Preservation of Youth, by Moses Maimonides. ($2.75, *Philosophical Library, New York 16, N. Y.)* A translation of Maimonides' essays on health.

The Physiology of Man, by L. L. Langley, Ph. D., and E. Cheraskin, M. D. ($6.95, Second edition, *McGraw-Hill Book Company, Inc., New York 36, N. Y.)* Presenting the basic physiological processes in an integrated and meaningful pattern.

Year Book of Obstetrics and Gynecology: 1957-58 Series, edited by J. P. Greenhill, M. D. ($7.50, *The Year Book Publishers, Chicago, Ill.)* This book is up to its usual standard of 589 pages crammed full of reports from the literature with editorial comment.

Year Book of Pediatrics: 1957-58 Series, edited by Sydney S. Gellis, M. D. ($7.50, *Year Book Publishers, Chicago 11, Ill.)* Here we have

ANSWERING DOCTORS' QUESTIONS . . .

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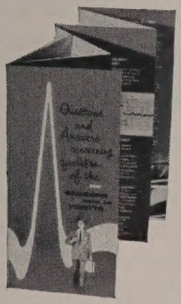

The text and pictures in this new 12-page booklet tell the story of the Sanborn Visette ECG in a unique way: *as answers to actual questions asked by hundreds of doctors* — at medical conventions, in correspondence, in conversations with Sanborn people. Many of these questions are probably ones you might also ask, to get a clear picture of just how a Visette might fit into *your own* practice and diagnostic procedures. Here are facts *you* can use, presented from the *doctor's* point of view.

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370 pages abstracted from the current literature with sound editorial directional comment.

The Epileptic Seizure, by Cosimo Ajmone-Marson, M. D., and Bruce L. Ralston, M. D. ($6.00, *C. C. Thomas Publisher, Springfield, Ill.)* This book discusses the functional morphology and diagnostic significance of such seizures and gives a clinical electrographic analysis of Metrazol®-induced attacks. It presents a pattern of the entire epileptic seizure in detail and places emphasis not only upon the different signs but also upon their temporal relationship in the course of the attack.

Borderline Cases of Hodgkin's Disease, by L Offerhaus. ($4.50, *Gregory Lounz, 11 E. 45th Street, New York 17, N. Y.)* The difficulties encountered in discussing borderline cases of Hodgkin's Disease are several, and the subject abounds in literary reviews. Grossly, the publications can be divided into two categories—the German studies from Sternberg's first publication in 1898 until his death in 1936. Thereafter, the interest in lymphoid tumors dwindled in Germany and was taken over by American workers and Jackson and Parker culminated their efforts in their well known text in 1947. Recently there have been several revivals of interest in Europe. This book is a definite contribution to the compromising of opinion with regard to nomenclature and classification.

Extensile Exposure, by Arnold K. Henry, M. D., Dublin. ($10.00, 2nd edition, *Williams & Wilkins Company, Baltimore 2, Md.)* Bone carries our anatomy and forms its central fact, and bone wherever possible is made the core of each exposure. Even the few confined to nerves and vessels bring in a glimpse of skeleton and some of these (though well rehearsed in other books and easily accessible) are borrowed here again. They form the roots from which exposures spread and serve like roots to bind irrelative surroundings. It is a book that those who have need of exact knowledge of anatomy will enjoy and profit from reading.

One Surgeon's Practice, by Frederick Christopher, M. D. ($4.00, *W. B. Saunders Co., Philadelphia 5, Pa.)* This book records some personal observations and experiences, not only in the preparation for and the development of an average general surgical practice but also in the daily practical and detailed conduct of such professional work. Included are anecdotes and illustrated examples. The author, of course, is the editor of well known surgical textbooks.

The Spine Jack Operation for Scoliosis, by H. Leslie Wenger, M. D. ($2.00, *H. Leslie Wenger, M. D., 44 Gramercy Park North, New York 10, New York.)* Increasing divergent views and contradictory opinions concerning operations for this condition continue. Here we have the author's experience and his attitude toward the various operating procedures.

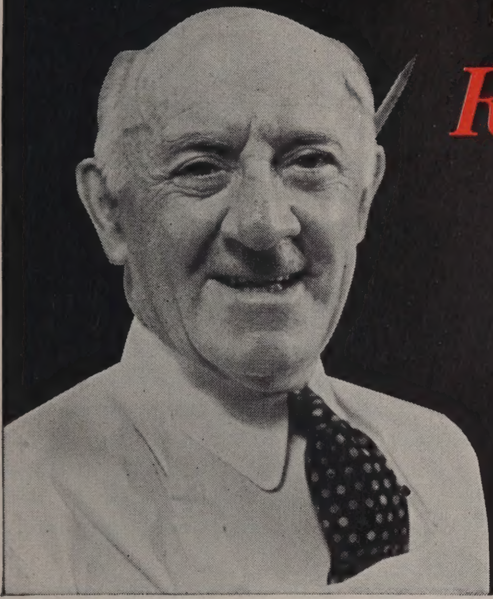
Modern Science and the Nature of Life, by William S. Beck. ($5.75, *Harcourt, Brace and Co., New York 17, N. Y.)* Life scientists are on the verge of the greatest break-through of all time. If the work now going on in biology bears fruit, scientists may soon bring into being the first living thing in the laboratory. Study of the simplest living thing, the viruses of the chemistry of the various living cells and the genes, the basic particles of which determine our heredity underlie the fundamental research in the question raised by this book. The author is a doctor of medicine and a research scientist in his own right.

Implementation of the Nursing Curriculum in the Clinical Fields, by Edna H. Treasure, R. N. ($4.50, *The Catholic University of America Press, 620 Michigan Ave., N. E., Washington 17, D. C.)* It is the proceedings of a Workshop on this subject which was held in June 1956. The purpose of this Workshop was to provide an opportunity for the discussion of mutual problems which exist in the nursing service and the nursing education personnel who work together with students in the patient situation in hospitals.

The Conquest of Loneliness, by Eric P. Mosse, M. D. ($3.75, *Random House, Inc., New York 22, N. Y.)* With the tools of his psychiatric and psycho-analytic experience, the author describes the facts, the defense mechanisms and the possible solution of mankind's most harassing problem—loneliness. Loneliness seems to be a characteristic and inescapable malady of modern man. It masquerades behind all kinds of symptoms; it disguises itself in all kinds of devious ways. The author attempts to give us an understanding out of the depths of his experience.

The Glamourway Reducing Handbook, by Betty Dean. ($2.75, *Comet Press, New York 14, New York.)* This reducing handbook written by one of the well known dietitians and experts in foods is unique and well planned for the readers who want to get the information which it contains.

The Development of the Child: A Guide for Parents, Teachers, Students and Others, by Agatha H. Bowley, Ph. D., with a Foreword by D. R. MacCalman, M. D. ($3.00, fourth edition, has 84 photographs; *E. and S. Livingstone, Ltd., Edinburgh,* distributed in U. S. A. by *Williams and Wilkins Co., Baltimore, Md.)* This latest edition



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Medical and Public Health Laboratory Methods, successor to the fifth edition of **Laboratory Methods of the United States Army,** by James S. Simmons, M. D., and Cleon J. Gentzkow, M.D. ($18.50, 115 engravings, 9 colored plates, *Lea and Febiger, Philadelphia 6, Pa.)* This sixth edition represents the cooperation of 35 authorities who have recorded their experiences in handling thousands of specimens under conditions enabling complete control. This edition also contains an immense amount of new subjects and tests.

Foot Troubles, by T. T. Stamm. ($4.75, *Philosophical Library, New York 16, N. Y.)* This is a short but comprehensive illustrated survey valuable to all foot sufferers, chiropodists, shoemakers, athletes and medical auxiliaries of every kind.

Vitamin A, by Thomas Moore, Sc. D. ($14.00, *Elsevier Publication, Van Nostrand Co., Inc., Princeton, N. J.)* The Deputy-Director of the Dunn Nutritional Laboratory at Cambridge, England, has brought us up to date, giving us the benefits of the 30 years that he has been actually engaged in research with the vitamin. This is, therefore, a standard book of reference.

Heredo-Retinopathia Congenitalis, by Carl H. Alstrom, M.D. *(Karolinska Institute, Stockholm 60, Sweden.)* The total material investigated includes 105 families of which a brief account is given. In these families, 15 liveborn children died before the age of one year. One died at birth, and one on the sixth day after birth. Of the remaining 13, seven died before the age of six months. They are not included in the genetical statistical calculations which are based on the children who survived the first year of life. Of these children, 175 exhibited blindness or impaired eyesight soon after birth or during the first year of life. No other cases of blindness or decreased vision were found in this sibship. They comprise an additional 303 sibs who as far as was possible to ascertain, in the course of extensive fieldwork, had unimpaired vision.

The Physiology of the Nervous System, by E. G. Walsh and John Marshall. ($9.50, *Longmans, Green and Co., New York 3, N. Y.)* This text on physiology forms an introduction to clinical work since it is based on the functional approach. One third of the book is devoted to tumors and a large section on the causation of new growths is a masterly discussion of an enormous field. The usefulness of the book is enhanced by the historical treatment of the subjects.

Trends in Gerontology, by Nathan W. Shock. ($4.50, 2nd edition, *Stanford University Press, Stanford, Calif.)* Recent developments in this field are described in the completely revised edition of this book. We get a comprehensive view of the various problems of aging. Interest is growing rapidly in this subject and there are many new developments in research and in programs all of which are treated in this volume.

Headache; Diagnosis and Treatment, by Robert E. Ryan, M. D. ($6.75, 2nd edition, *The C. V. Mosby Co., St. Louis 3, Mo.)* Recent advances in methods of diagnosis and treatment of headache make necessary this new edition. Many new aids are now available to help the physician establish a correct diagnosis and many new preparations and procedures have appeared to improve treatment both symptomatically and prophylactically. Hence, this is a book that almost every physician will need for reference.

The Year Book of Medicine, 1957 - 1958 Series, by Paul B. Beeson, M. D., and others. ($7.50, *Year Book Publishers, Inc., Chicago 11, Illinois.)* This series, of course, has become standard in the libraries of a very large number of American physicians. This particular text is up to the standard of the previous editions. There is no better way to review the advances in medicine than to spend the long winter evenings with this text.

Pathological Histology, by Robertson F. Ogilvie, M. D. ($11.00, 5th edition, 334 photomicrographs in color, *Williams and Wilkins Company, Baltimore 2, Md.)* The purpose of this book is to overcome the difficulty and uncertainty inherent in teaching large classes. The students see the sections demonstrated on the screen and then examine their own series under their own microscope and then they have this text as a sort of atlas with which to review and make certain that they understand the changes which are seen in the particular sections.

Illustrated Preoperative and Postoperative Care, by Philip Thorek, M. D. ($5.00, *J. B. Lippincott Co., Philadelphia 5, Pa.)* Emphasizes the need of laboratory tests when indicated, but this can be overdone. Patients are often studied to death. It is indefensible to prepare them for death instead of the operation. These illustrations help to do the right things in emergencies.

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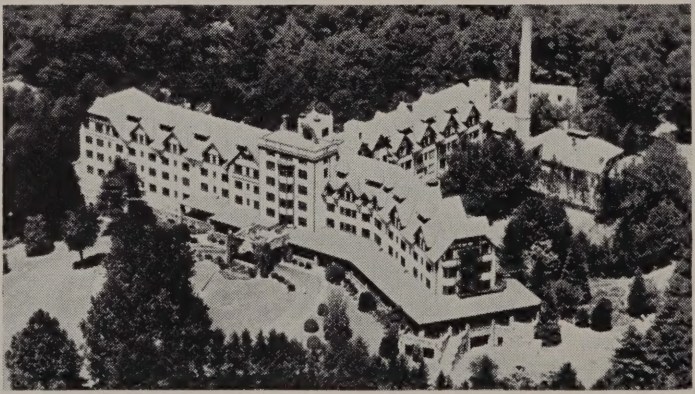

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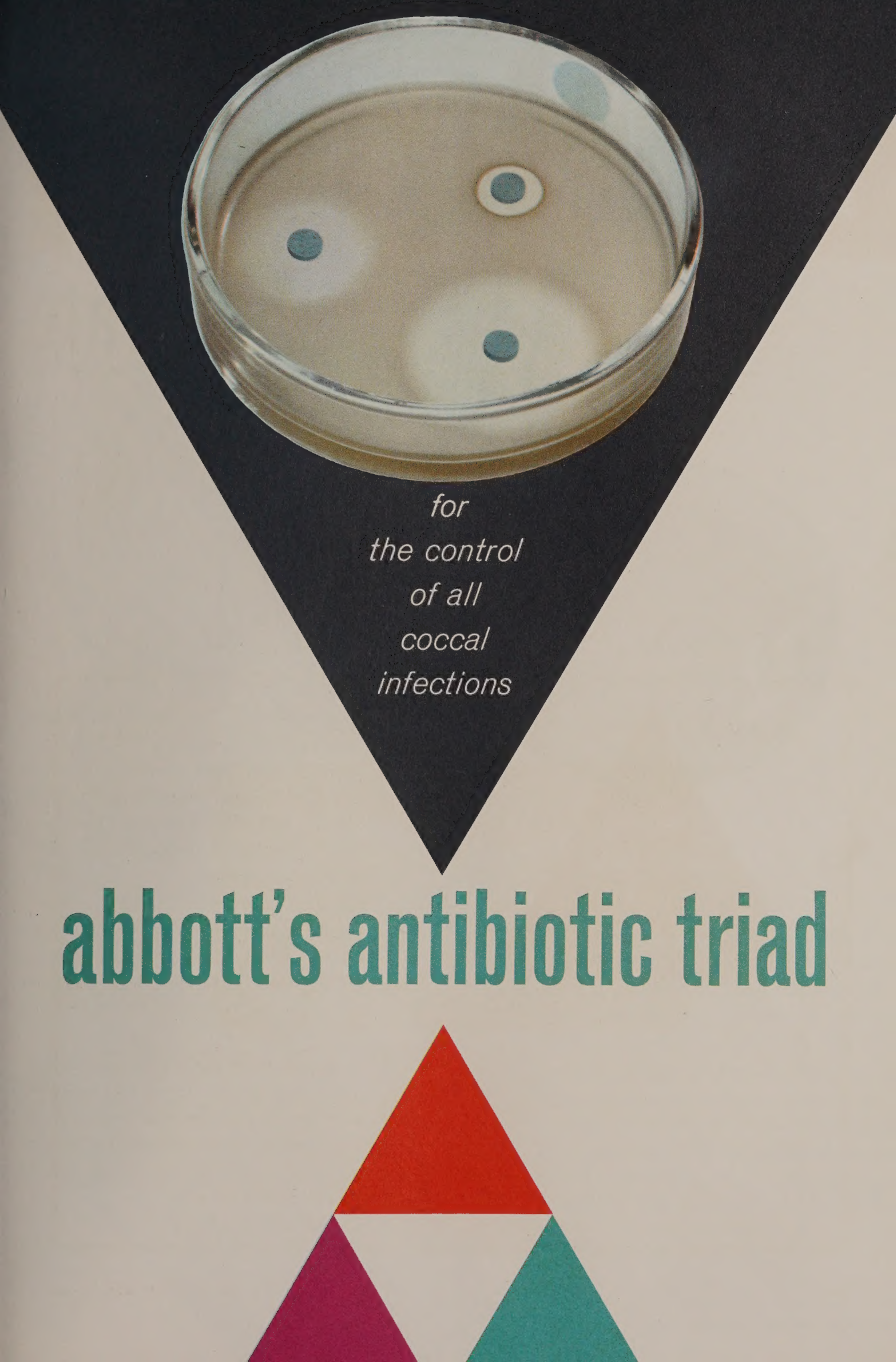

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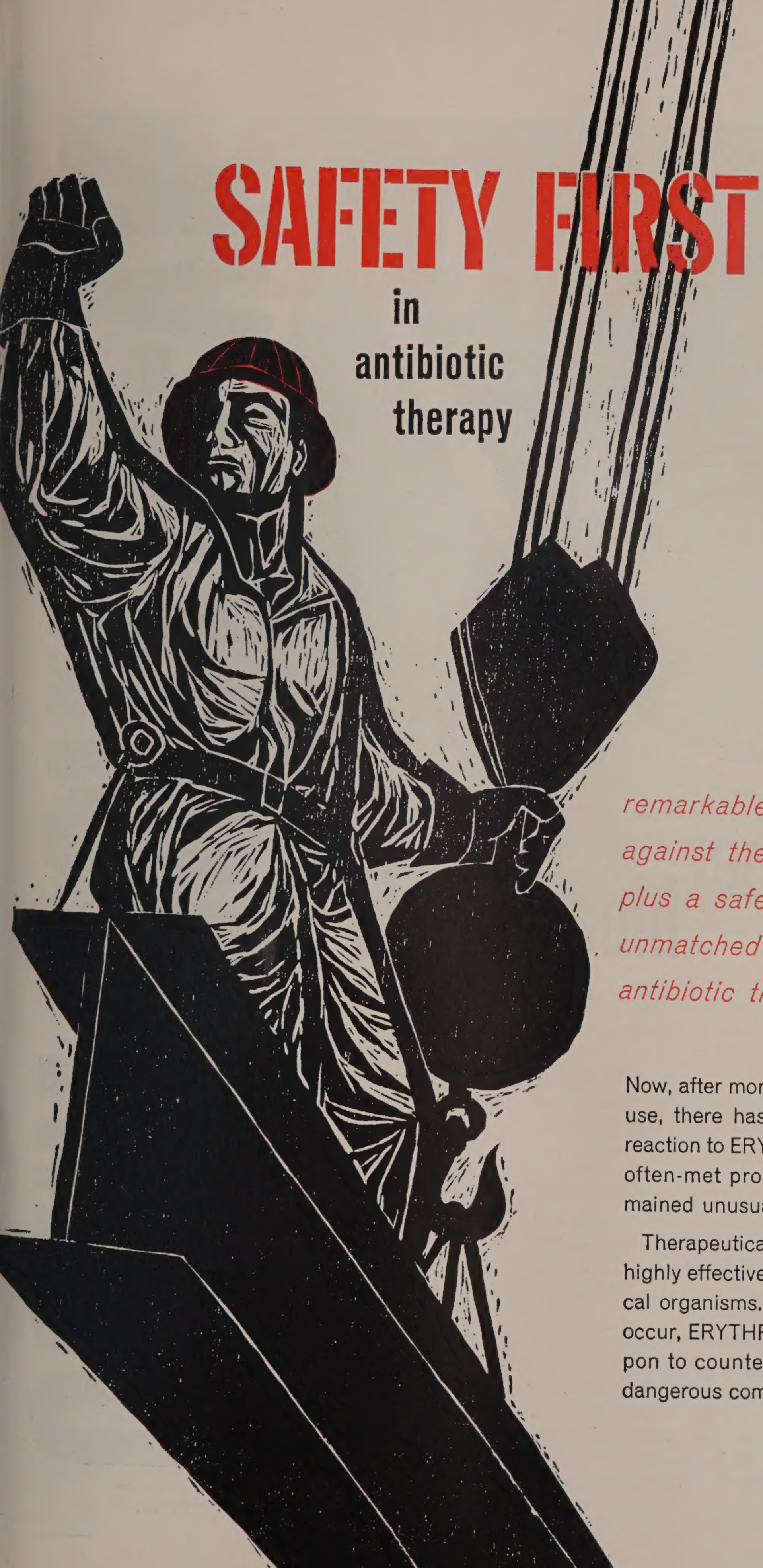

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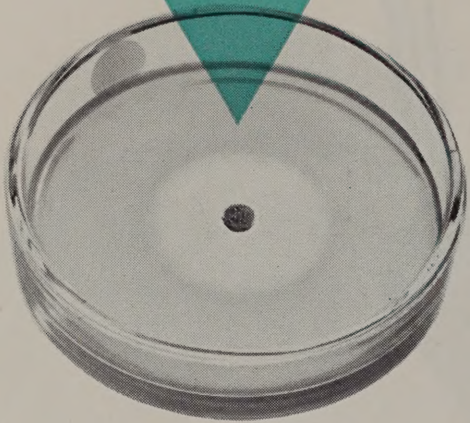

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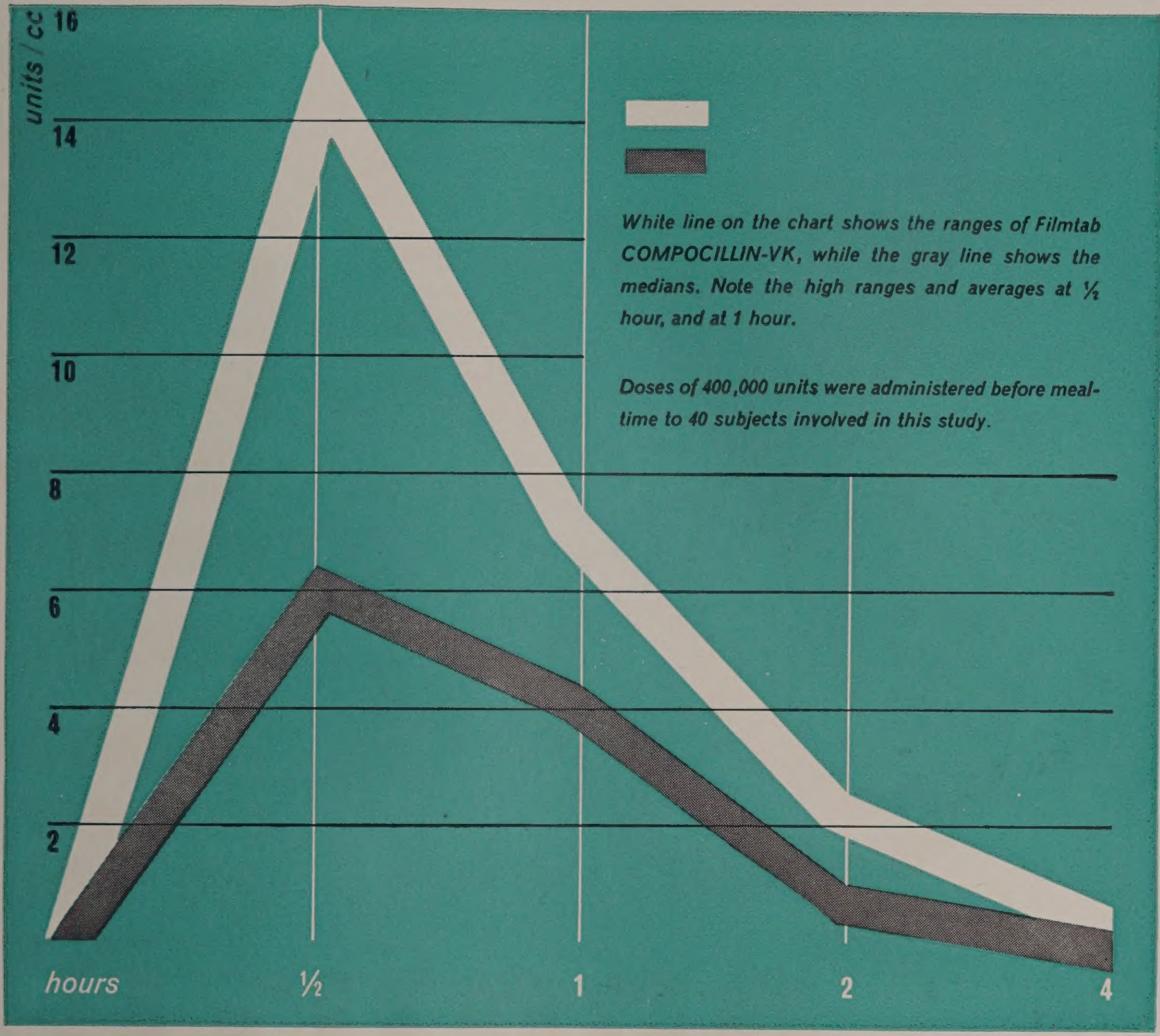

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COMPOCILLIN-VK is indicated whenever you desire oral penicillin therapy. In severe infections, oral penicillin should be supplemented by parenteral therapy to obtain the maximum therapeutic response.

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Dosage:

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Supplied:

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For Oral Solution, COMPOCILLIN-VK comes in dry granules for easy reconstitution with water. Cherry-flavored, the granules come in 40-cc. and 80-cc. bottles. Each 5-cc. teaspoon of solution represents 125 mg. (200,000 units) of potassium penicillin V.

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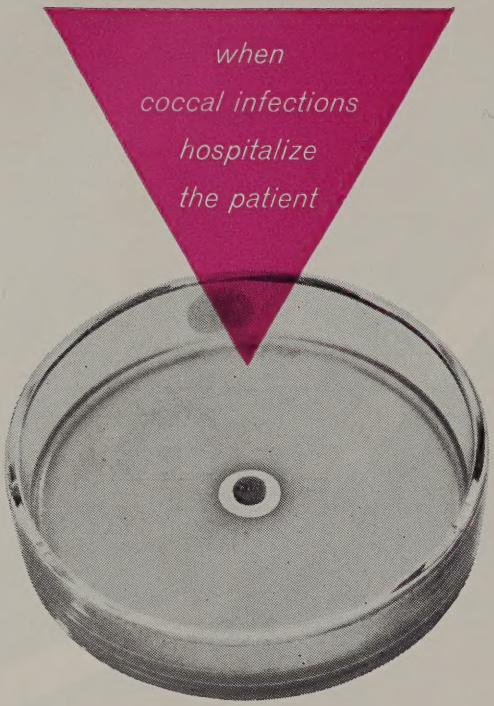

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Against a wide range of staphylococcal, streptococcal, pneumococcal and enterococcal infections. A drug of choice for treating serious infections caused by organisms that resist all other antibiotics.

dosage:

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provides clinical effectiveness against resistant staphylococci and enterococci[2]

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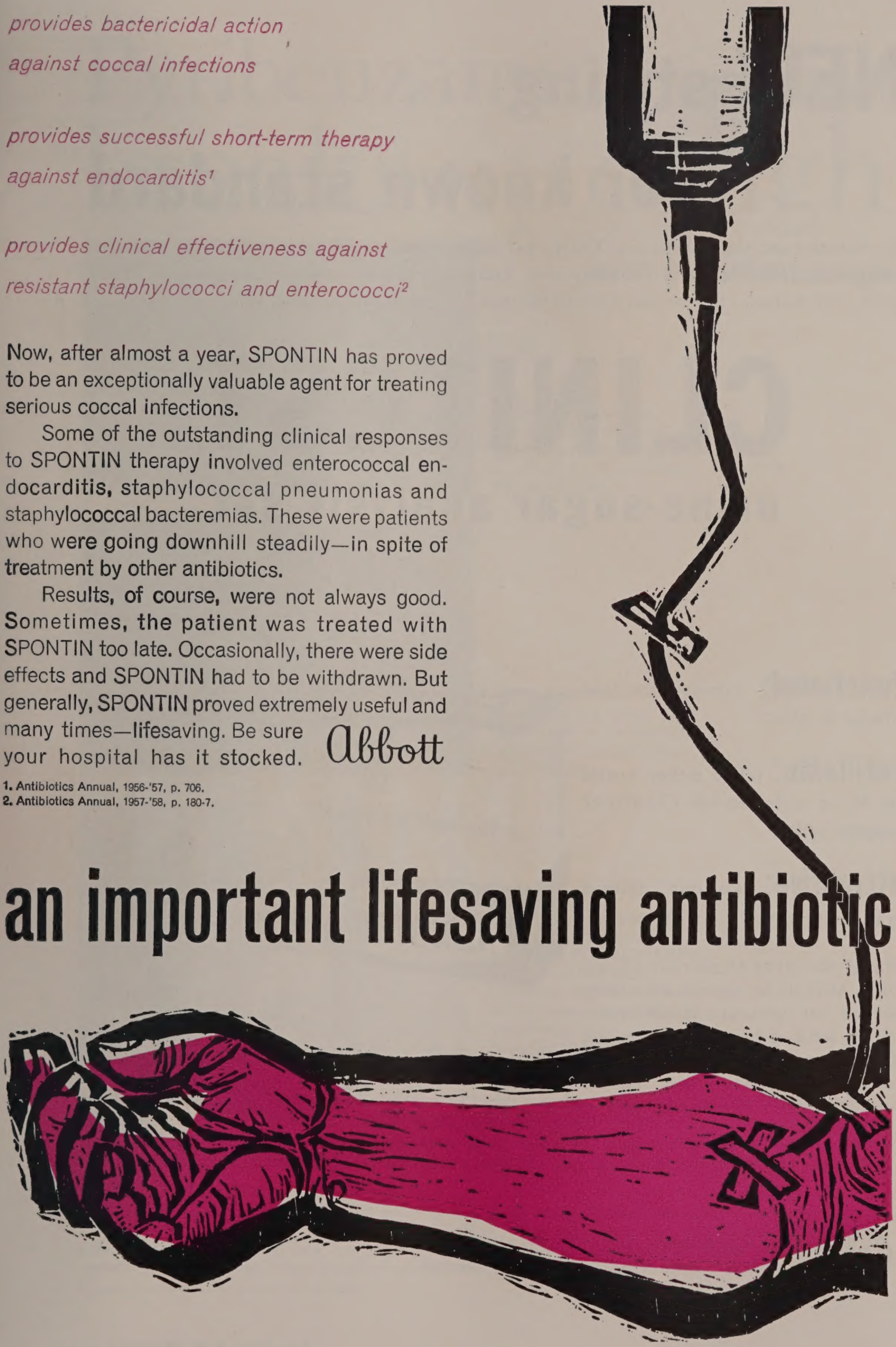
Results, of course, were not always good. Sometimes, the patient was treated with SPONTIN too late. Occasionally, there were side effects and SPONTIN had to be withdrawn. But generally, SPONTIN proved extremely useful and many times—lifesaving. Be sure your hospital has it stocked.

Abbott

[1] Antibiotics Annual, 1956-'57, p. 706.
[2] Antibiotics Annual, 1957-'58, p. 180-7.



an important lifesaving antibiotic

NEW styling for known standard

To diabetics and their physicians, Clinitest means rapid *and* reliable urine-sugar testing—standardized for accurate results every time. And now, the new streamlined model (No. 2105) gives your diabetics this standard test in the best looking, most efficient form.

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BRAND

urine-sugar analysis set

- **functional:** full-view test tube always in place
- **refillable:** takes either bottle of 36 or sealed-in-foil Clinitest reagent tablets
- **attractive:** two-tone, neutral gray plastic case

Model No. 2105 Clinitest Urine-Sugar Analysis Set contains everything needed for accurate standardized testing: bottle of 36 Clinitest Reagent Tablets, test tube, unbreakable dropper. color scale—instruction sheet, analysis record, diabetic's identification card

Clinitest
urine-sugar analysis set
AMES
urine-sugar analysis set
Clinitest
BRAND
36
NO 2107
CLINITEST
REAGENT TABLETS

MODEL NO. 2105

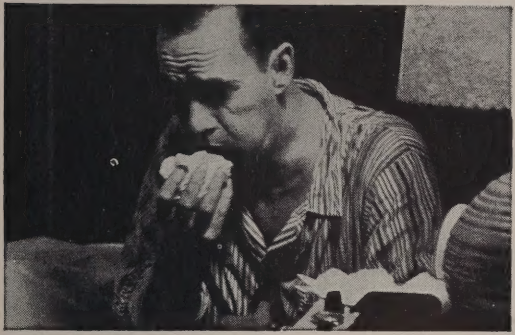
AMES COMPANY, INC • ELKHART, INDIANA
Ames Company of Canada, Ltd., Toronto

56758

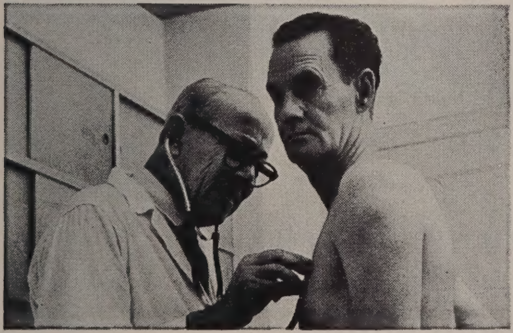
Pyribenzamine® EXPECTORANT breaks up cough

even persistent cough

Patient, factory worker, age 43, had suffered for months with persistent, dry cough, which he termed "smoker's hack."



Cough frequently interrupted his sleep, causing him to be nervous, irritable; his job efficiency was impaired.



Chest X-ray was negative and the plant physician prescribed PYRIBENZAMINE EXPECTORANT with Ephedrine. Patient noticed almost immediate relief–a week later felt "considerably better."

Pyribenzamine Expectorant with Ephedrine provides a unique combination of antitussive agents, which work three ways at once to break up the persistent cough: *Pyribenzamine* relieves histamine-induced congestion throughout the respiratory tract; *ephedrine* relaxes the bronchioles and makes breathing easier; *ammonium chloride* liquefies mucus, relieving dry cough and promoting productive expectoration.

Supplied: Pyribenzamine *Expectorant with Ephedrine,* containing 30 mg. Pyribenzamine citrate (equivalent to 20 mg. Pyribenzamine hydrochloride), 10 mg. ephedrine sulfate and 80 mg. ammonium chloride per 4-ml. teaspoon. Also available: Pyribenzamine *Expectorant with Codeine and Ephedrine,* same formula as above with the addition of 8 mg. codeine phosphate per 4-ml. teaspoon (exempt narcotic).

Pyribenzamine® citrate (tripelennamine citrate CIBA)

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ARTHRITIS... OR GOUT?

GOUT—THE DIAGNOSTIC PROBLEM

Clinical "curiosity" rather than clinical "instinct" is the key to accurate diagnosis of gout. Visible manifestations may not appear until late in the course of the disease. Moreover, the patient's description of the pain and the site of the pain may not differ markedly from other articular disorders.

THE FOLLOWING FINDINGS ARE HIGHLY INDICATIVE OF GOUT: (1) *Tophaceous deposits* resulting in irregular, asymmetrical deformity of joints; (2) *Elevated serum uric acid levels* (above 6 mg.%); (3) *Pain relief with colchicine.* When findings suggest gout, therapy with 'Benemid' should be started immediately.

BENEMID®—AN EFFECTIVE URICOSURIC AGENT

'Benemid' is firmly established as an *effective* and exceptionally *safe* uricosuric agent. 'Benemid' approximately doubles the excretion of uric acid; reduces serum uric acid levels toward normal; often prevents formation of new tophi, and gradually mobilizes existing uric acid deposits; minimizes incidence and severity of future attacks.

'Benemid' is of remarkably low toxicity—usually so low as to be clinically insignificant—even in patients who have been on uninterrupted therapy for almost a decade. The uricosuric effects of salicylates and 'Benemid' are mutually antagonistic and these compounds should not be used together.

RECOMMENDED DOSAGE: 0.25 Gm. (½ tablet) twice daily for one week followed by 1 Gm. (2 tablets) daily in divided doses.

BENEMID®

PROBENECID

A SPECIFIC FOR GOUT

MSD **MERCK SHARP & DOHME**

DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

BENEMID is a trade-mark of Merck & Co., Inc.

For *Real Pain* ...give real relief:

A.P.C. WITH **Demerol**®
tablets

Each tablet contains:

Aspirin	200 mg.	(3 grains)
Phenacetin	150 mg.	(2½ grains)
Caffeine	30 mg.	(½ grain)
Demerol hydrochloride	30 mg.	(½ grain)

Average Dose:

1 or 2 tablets.

Narcotic blank required.

Potentiated Pain Relief

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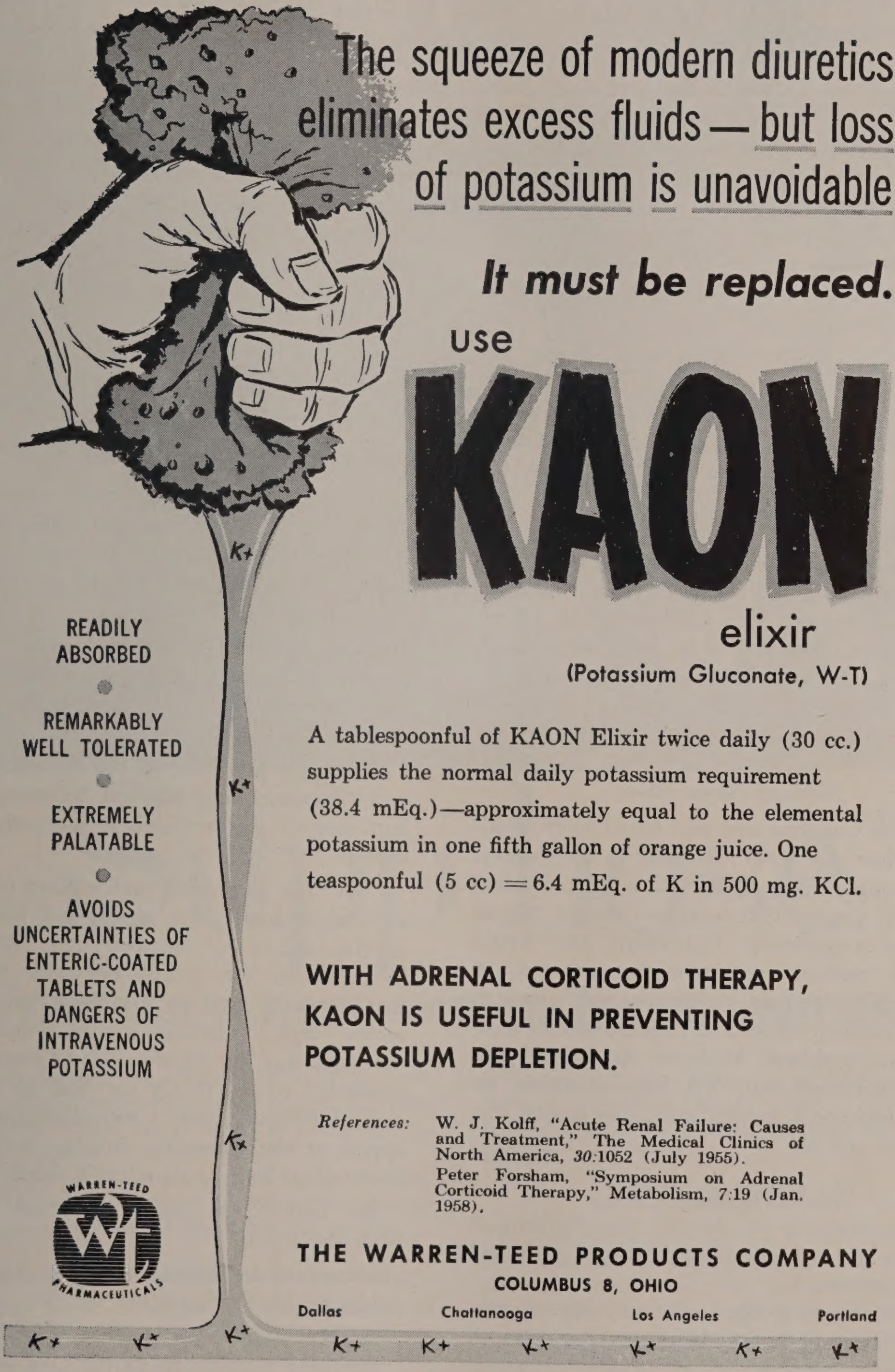
New York 18, N. Y. • Windsor, Ont.

Demerol (brand of meperidine),
trademark reg. U.S. Pat. Off.

The purity, the wholesomeness, the quality of Coca-Cola as refreshment has helped make Coke the best-loved sparkling drink in all the world.

DRINK Coca-Cola REG. U.S. PAT. OFF.

SIGN OF GOOD TASTE



The squeeze of modern diuretics eliminates excess fluids — but loss of potassium is unavoidable

It must be replaced.

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(Potassium Gluconate, W-T)

READILY ABSORBED

REMARKABLY WELL TOLERATED

EXTREMELY PALATABLE

AVOIDS UNCERTAINTIES OF ENTERIC-COATED TABLETS AND DANGERS OF INTRAVENOUS POTASSIUM

A tablespoonful of KAON Elixir twice daily (30 cc.) supplies the normal daily potassium requirement (38.4 mEq.)—approximately equal to the elemental potassium in one fifth gallon of orange juice. One teaspoonful (5 cc) = 6.4 mEq. of K in 500 mg. KCl.

WITH ADRENAL CORTICOID THERAPY, KAON IS USEFUL IN PREVENTING POTASSIUM DEPLETION.

References: W. J. Kolff, "Acute Renal Failure: Causes and Treatment," The Medical Clinics of North America, *30*:1052 (July 1955).

Peter Forsham, "Symposium on Adrenal Corticoid Therapy," Metabolism, 7:19 (Jan. 1958).

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You and Your Public . . .

Grass Roots Drought May Be Why Medicine's Legislative Crops Fail to Flourish

THE physician's public includes more than just his patients. His public is everybody, particularly in this day when medicine and medical men are of such great interest to the public.

And this "everybody" in the physician's public includes his fellow citizens elected to serve in office. Further, it includes those who see to it that these persons are elected.

It is for this reason that an article in the August 25 issue of *Medical News* is extremely pertinent. It points out that if those elected to office know and understand medicine's views before their election, then many of medicine's last-ditch legislative battles could be avoided.

Ohio physicians do a better job of keeping in contact with legislators than do the physicians in some states. Nevertheless, Ohio doctors can't be smug. They can do a far better job. Also, many more of them should be doing something.

Here's the *Medical News* article in its entirety. Read it. Ponder it. Follow the excellent advice it offers.

* * *

Medical News Says

The 85th Congress saw and heard more medical men than any other Congress in our history.

A seemingly endless procession of physicians paraded up Capitol Hill to appear before various committees considering legislation that would affect the medical profession in one way or another. They've read statements and answered questions on such subjects as increased social security, old age problems, Medicare, the Forand bill, the Jenkins-Keogh bill, VA hospitalization, research facility needs, medical education grants—the list goes on and on.

No Happy Experience

For the majority of doctors who testified at committee and subcommittee hearings, it wasn't a happy experience.

One prominent medical educator, after a particularly harassing session before a House health subcommittee, summed it up wryly: "It would seem that we're not among friends."

It is increasingly apparent that he's right. The question is, why?

Why does organized medicine continually find itself making last-ditch, back-to-the-wall fights to convince noncommittal or unsympathetic legislators that its views on proposed health legislation are valid?

Why are physicians being constantly exhorted —usually at the eleventh hour—to wire their representatives in state house and Congress, in order to make known the honest beliefs they've held for years?

And why, in so many instances, do the last-minute society resolutions, explanations and telegrams fail to accomplish their purpose?

Individual Doctors Blamed for 'Drought'

Dr. Ervin L. Bernhart, new president of the Conference of Presidents and Other Officers of State Medical Associations, has come up with an answer—though it may not, he concedes, be the *whole* answer.

There is, says Dr. Bernhart, a drought in the political grass roots of American medicine. And the blame for it can be laid at the individual doctor's door.

As a past president of the Milwaukee County and Wisconsin State Medical Societies, Dr. Bernhart doesn't absolve himself and other medical leaders.

"We, the presidents and officers of our state medical societies, have simply not laid the facts on the line to our members. . . . We ourselves have become too complacent with the illusion that somebody will do something when the time comes—that resolutions rightly timed will turn the tide; that the legislature or Congress can be persuaded to see things our way by honest and skillful lobbying; that a well-documented, strong appeal at the committee hearing will cause the law-making body to do what it should."

But nothing, he points out, could be further from the truth.

"Medicine is failing to protect itself and the public health by forgetting the first fundamental of grass-roots politics; personal contact."

Speaking to members of the Conference in San Francisco, Dr. Bernhart didn't mince words. "We've done a lot of grass-roots *talking* at medical meetings as far back as I can remember—but for some reason, our talk seems to have been

†Trademark *Patent #2,841,971
NOW! THE SHEER ALL-NYLON STOCKING
THAT SUPPORTS WITHOUT USING RUBBER!

Supp-hose†*

FOR LEG FATIGUE AND MILD VARICOSITIES

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SO MANY WOMEN COMPLAIN ABOUT LEG FATIGUE!

As you know, expectant mothers, housewives, working women, and women with mild varicosities all complain about discomfort of the extremities. Supp-hose eases this leg fatigue and gives gentle support all day long. Yet Supp-hose contains no rubber! Every stitch is fine nylon with a special twist that provides an elastic quality.

A VERY ECONOMICAL STOCKING!

Patented Supp-hose costs a woman just one-third what she usually pays for heavier surgical stockings. And wear tests indicate Supp-hose should give five times the wear of ordinary nylons. Supp-hose is available in proportioned sizes in beige, natural and white. At drug and department stores.

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nothing but hot air. Without some grass-roots *action,* all of our talking is worthless."

Must Make Facts Known

As one example, he cited constant severe attack on the profession for "increased cost of medical care." Yet, he pointed out, few of the critics have made any effort to distinguish the costs of hospitalization and ancillary services from the cost of doctors' services. "We know the facts," says Dr. Bernhart, "but they won't do us any good unless we can make them known in good time to the legislators."

Most state and national politicians begin their careers in the city council or the county board. That's where they form their first impressions of physicians—and where they *should* first become sympathetic with the problems confronting medicine. Says Dr. Bernhart: They don't. And the reason is that the individual doctors in the community haven't taken the time or trouble to give them accurate information.

How many doctors, he asks, are at this moment active in helping to choose the candidates who will be elected to the next Congress? Or in furnishing medicine's side of the story to those who have already been chosen? The number is pitifully small.

As a result, he concludes glumly, candidates will be elected to office to get favors for the special groups—often smaller than medicine—who have organized to put them there. "Then, after election, the medical profession will be called upon to make a last-ditch effort to prove the validity of its program to legislators already pledged to vote against it."

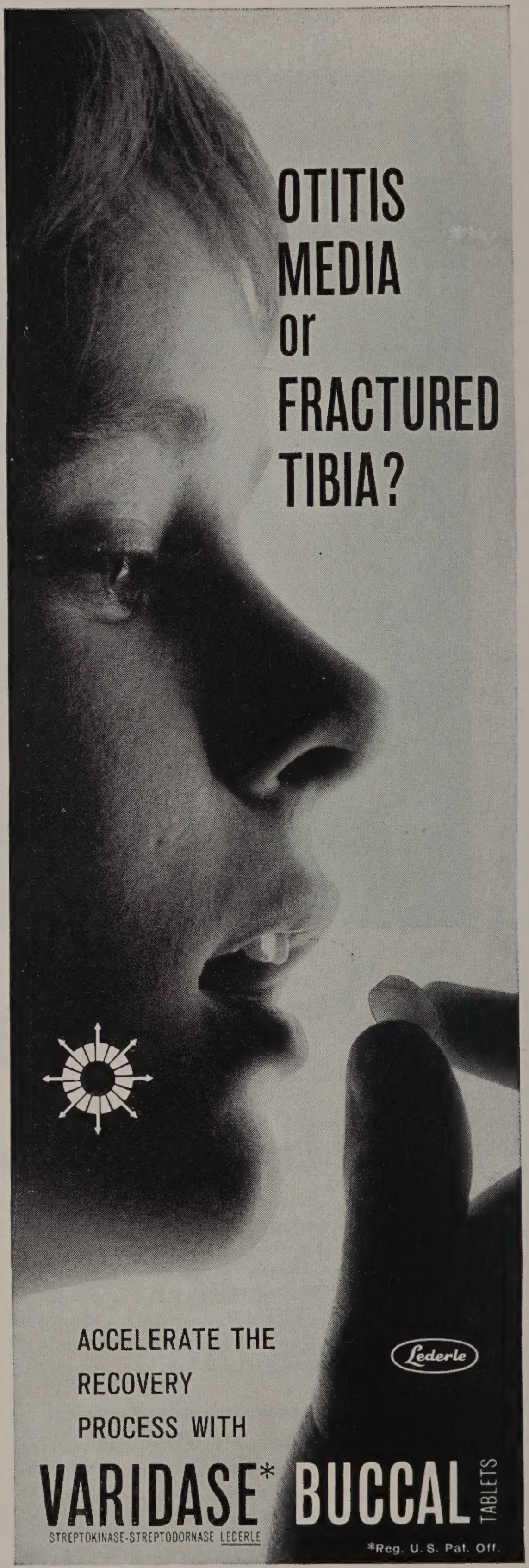
It's up to the individual doctor to fight for organized medicine's opinions at the grass-roots level, to inform, to choose, to elect.

"If we don't," concluded Dr. Bernhart, "we're going to be in the same fix every year from now on."

Growth of Health Professions Shown in New U. S. Report

A newly published Census Bureau report makes some interesting statistical disclosures on the health professions since 1920. While engineers were increasing more than 300 per cent between 1920 and 1950, accountants and auditors more than 200 per cent and social workers by 100 per cent, the number of MD's rose less than 35 per cent. For all professional and technical workers, the increase was approximately 125 per cent.

The increase in dentists was correspondingly small, from 56,152 in 1920 to 75,944 in 1950. Optometrists doubled in number, to 14,916. Pharmacists went from 64,236 ot 90,307; veterinarians' gains were negligible—from 13,494 to 13,679.



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TETRACYCLINE-ANTIHISTAMINE-ANALGESIC COMPOUND LEDERLE

A versatile, well-balanced formula for treating common upper respiratory infections, particularly during respiratory epidemics; when bacterial complications are observed or are likely; when patient's history is positive for recurrent otitic, pulmonary, nephritic, or rheumatic involvement.

CHECKS SYMPTOMS: Includes traditional components for rapid relief of the traditional nonspecific nasopharyngitis, symptoms of malaise, chilly sensations, inconstant low-grade fever, headache, muscular pain, pharyngeal and nasal discharge.

Available on prescription only.

Adult dosage for ACHROCIDIN Tablets and new caffeine-free ACHROCIDIN Syrup is two tablets or teaspoonfuls of syrup three or four times daily. Dosage for children according to weight and age.

TABLETS *(sugar coated)*
Each Tablet contains:

ACHROMYCIN® Tetracycline	125 mg.
Phenacetin	120 mg.
Caffeine	30 mg.
Salicylamide	150 mg.
Chlorothen Citrate	25 mg.

Bottles of 24 and 100.

SYRUP *(lemon-lime flavored)*
Each teaspoonful (5 cc.) contains:

ACHROMYCIN® Tetracycline equivalent to tetracycline HCl	125 mg.
Phenacetin	120 mg.
Salicylamide	150 mg.
Ascorbic Acid (C)	25 mg.
Pyrilamine Maleate	15 mg.
Methylparaben	4 mg.
Propylparaben	1 mg.

Bottle of 4 oz.

• adenitis
• sinusitis
• otitis
• bronchitis
• pneumonitis
prevents the . . . . . multifarious sequelae

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Washington Roundup . . .

News from the Nation's Capital of Interest to Physicians; Developments in Medical and Health Fields

Construction of the National Library of Medicine building is expected to start sometime in the spring of 1959. President Eisenhower readily signed into law the Congressional bill providing $7.3 million for construction and equipment of the building.

* * *

White House Conference on Aging is scheduled to be held sometime in January, 1961. Purpose is to "arrive at facts and recommendations concerning the utilization of skills, experiences and energies and the improvement of the conditions of our older people." Date was set two years in advance to enable state and local governments, the professional and lay persons working in this field to prepare and collect material in line with the purpose of the conference.

* * *

Western Reserve University has been included among 51 teaching, clinical and research institutions that will get a total of $12,789,758 in matching funds to help them build and equip facilities for scientific studies in medical and biological sciences. WRU allocation amounts to $1,253,686.

* * *

With applicants for military commissioning for residency deferment or early active duty lagging far behind 1957 rate, armed forces medical officer procurement program will be compelled to call upon Selective Service to provide doctor-draftees next spring. Since local draft boards prefer to induct residents rather than physicians in private practice, hospitals may be hardest hit.

* * *

On heels of complaint that Federal Trade Commission failed to curb fraudulent advertising for weight-reducing claims, House Government Operations Committee has charged FTC with laxity in cracking down on misleading advertising involving tranquilizer drugs and dentifrices.

* * *

Despite so-called pushbutton warfare "fought from a sitting position," it apparently still takes two feet to make a soldier. August issue of *Military Medicine* contains article pointing out that foot injury and disease is still a big army problem.

World Medical Association, which observed the tenth anniversary of its founding September 18, drew warm praise from Senator John Bricker for its accomplishments in Senate speech.

* * *

New executive director of Medicare is Col. Floyd L. Wergeland, succeeding Maj. Gen. Paul I. Robinson, who became Metropolitan Life Insurance Co. coordinator of medical relations following his recent military retirement.

* * *

Late summer rise in paralytic polio cases climbed well above 1957 rate. Surgeon General said physicians may wish to recommend fourth shot of vaccine for children who had third shot more than a year; American Academy of Pediatrics has recommended fourth shot as well. Biggest job, however, is to get at least three shots into millions under 40 who haven't even had one shot.

* * *

Christ Hospital Institute of Medical Research, Cincinnati, is one of eight institutions awarded Public Health Service contracts for further research in cancer chemotherapy.

* * *

Hospital and institutional construction by private interests showed a sharp gain in the 1958 construction season, some 20 per cent over the 1957 level, according to the Departments of Commerce and Labor.

* * *

AMA's efforts to save post of assistant secretary of defense for health and medical affairs have been successful. Defense Secretary Neil McElroy has notified the incumbent, Dr. Frank S. Berry, that the post will be retained under forthcoming Defense Department reorganization. The decision has the approval of the President.

* * *

Veterans Administrator Sumner G. Whittier has called for explicit law clearly defining requirements for eligibility for VA hospital and medical care. Non-service-connected care is a main issue.

Relieve moderate or severe pain

Reduce fever

Alleviate the general malaise of upper respiratory infections

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'EMPIRIN' COMPOUND® WITH CODEINE PHOSPHATE*

maximum codeine analgesia/optimum antipyretic action

*Subject to Federal Narcotic Regulations

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York

Symbols OF PROVEN PAIN RELIEF

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gr. 1

'TABLOID'
3
BRAND

gr. ½

'TABLOID'
2
BRAND

gr. ¼

'TABLOID'
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BRAND

gr. ⅛

Formulas for dependable relief...

...from moderate to severe pain complicated by tension, anxiety and restlessness.

'CODEMPIRAL'® NO. 3*

Codeine Phosphate	gr. ½
Phenobarbital	gr. ¼
Acetophenetidin	gr. 2½
Aspirin (Acetylsalicylic Acid)	gr. 3½

'CODEMPIRAL'® NO. 2*

Codeine Phosphate	gr. ¼
Phenobarbital	gr. ¼
Acetophenetidin	gr. 2½
Aspirin (Acetylsalicylic Acid)	gr. 3½

...from pain of muscle and joint origin, simple headache, neuralgia, and the symptoms of the common cold.

'TABLOID'

'EMPIRIN' COMPOUND®

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Acetophenetidin	gr. 2½
Aspirin (Acetylsalicylic Acid)	gr. 3½
Caffeine	gr. ½

...from mild pain complicated by tension and restlessness.

'EMPIRAL'®

Phenobarbital	gr. ¼
Acetophenetidin	gr. 2½
Aspirin (Acetylsalicylic Acid)	gr. 3½

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In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

DEFINITION OF EMERGENCY SERVICE WELL WORTHWHILE

The Knox County Medical Society recently completed a project that other medical societies may find worthwhile to follow. The project involved a study of the number and types of emergency cases treated at Mount Vernon's two hospitals.

As a result of the study, Dr. James McLarnan, president of the society, issued a public statement designed to offset some of the unnecessary and impractical demands the public often makes on such services.

Dr. McLarnan explained to the people of Mount Vernon that Knox County Medical Society members provided the service to assure prompt emergency care when the patient cannot contact or has no family physician.

He added, "Emergency treatment has been defined as that given when a life is at stake and must be administered immediately. However, in this community, it has been modified to include treatment which cannot ordinarily be provided in a physician's office.

"As the emergency service is manned entirely by physicians in active practice in Mount Vernon, this service is not intended to provide round-the-clock out-patient care for minor illness or to interfere in any way with a regular doctor-patient relationship. In all cases, except those where life is immediately in danger, a person should consult his regular physician for instructions."

This problem is not limited to Mount Vernon. Other medical societies face it, and they may find that to follow the Knox County Medical Society's action may help to eliminate a time-consuming and costly habit on the part of too many people.

INVESTIGATE BEFORE CHANGING MODE OF PRACTICE

In its recent booklet, "Articles of Association for Unincorporated Associations," the Law Department of the AMA makes this most pertinent statement which should be heeded by those physicians who may be contemplating forming an unincorporated association for tax advantages:

"It must be remembered that the legal and tax involvements of corporations and unincorporated associations are intricate. They should be utilized in group medical practice only if the financial advantages are clearly persuasive and will not interfere with traditional physician-patient relationships, and then only upon the advice of competent legal and tax counsel."

For Ohio physicians, this additional "remember" should be added: Remember, the corporate practice of medicine in Ohio is unlawful and that certain practices by groups, organizations, partnerships, etc., other than corporations, also are unlawful and unethical. The recent statement by The Council of the Ohio State Medical Association, published in the July, 1958, issue of *The Journal,* points up this question in detail.

It would be wise for any physician contemplating a mode of practice which differs from the traditional personal physician-patient relationship to investigate before he changes.

LAWYERS TO BE SURVEYED ON MEDICAL MATTERS

A survey of attorneys on various subjects of mutual interest to physicians and lawyers will be conducted early this fall by the AMA's Law Department. Approximately 10,000 lawyers will be asked to answer questions on interprofessional relations, medical professional liability and expert medical testimony.

The need for such a study is evidenced by the fact that as high as 80 per cent of all cases tried today require medical testimony and that seven out of 10 personal injury cases are decided on medical rather than legal considerations.

The medical profession should be aware of the problems of attorneys and the role of medicine in the judicial system.

Information which the study will reveal can be used to promote good working relations between physicians and attorneys. It is a very worthy project. It is hoped the lawyers surveyed will cooperate.

HOW ABOUT SOME SALES TALK ON PREVENTIVE MEDICINE?

Getting the people to realize the value of good preventive medicine has never been an easy thing to sell. More and more persons today are aware of its value but still there are too many who wait until illness hits before thinking about their physical and mental well-being.

Physicians in their chats with their patients—and others—can do a job of selling preventive medicine, if they will but take the time to do so.

Why do we talk about this? Because of the following editorial which appeared in the official bulletin of the Columbus City Health Department recently:

"Probably because we have so little of it in comparison with how much we'd like to have, the American people dislike to spend their money unless there's a definite need. Probably that's why those who disburse insurance are salesmen, rather than solicitors. And as we all know, creating the desire for a product is the foundation of successful advertising.

"That is why the average American family will wait until somebody is actually sick before they'll spend money with a doctor. We all have a desire to keep well people well, but we have to be exposed to salesmanship of one kind or another before we see the economy of spending our hard-earned dollars to protect our health.

"In the last few years, however, many farseeing folks are realizing the advantages of protective health practices. It's cheaper in dollars and cents and to a considerable degree it eliminates pain, illness, and unemployment.

"The program need not be elaborate. In fact, the simpler the better. One facet is a complete family record, kept in handy location, of all inoculations and physical and dental check-ups. Another is an understanding that pre-ailment attentions are an investment in good health. A third is a determination to follow a pre-arranged schedule any physician will be glad to assist in preparing.

"Immediate results may not be apparent, but over the years they will compose a firm argument in favor of preventive practices that easily could amount to the price of a new car or a substantial down payment on a home. Besides, regular visits to a physician or dentist when a child is obviously well tend to reduce his anxiety in future visits, whether he is confronted either with a routine or an emergency situation.

"A fitting slogan for such a program might be something like 'see your doctor when you're well and only see him once. If you wait until you're ill you'll be going back for months.' "

HOW ARE FOREIGN GRADUATES BEING SCREENED?

Asks a member:

What's being done to screen the foreign medical graduates who want to practice in the United States or prepared themselves for practice in this country?

Information from the AMA on this is as follows:

The Educational Council for Foreign Medical Graduates is sponsored by the American Hospital Association, the American Medical Association, the Association of American Medical Colleges, and the Federation of State Medical Boards of the United States. Its primary functions are, first, to provide information to foreign medical graduates wishing to come to the United States; second, to provide a means of assuring, before they come to this country, that foreign medical graduates seeking internships or residencies in American hospitals have the medical training and knowledge and the necessary command of English to serve effectively in those capacities.

Inquiries from almost 400 foreign medical graduates have been answered with letters and published materials since the ECFMG opened its office on Oct 1, 1957. The American Medical Qualification Examinations are of the multiple-response, objective type given in a single day with 200 questions in the morning and 200 in the afternoon. Included in the examination will be questions on medicine, surgery, pediatrics, obstetrics and gynecology, anatomy, physiology, biochemistry, microbiology, pharmacology, and pathology.

Passing of the three-way screening of credentials, of command of English, and of knowledge of medicine will gain for the foreign medical graduate the recommendation of the ECFMG's four sponsoring agencies that he be considered by hospitals, licensing boards, and specialty boards on the same basis as are graduates of American medical colleges.

NOTHING TO FEAR IF YOU'RE RIGHT

Unfortunately, some physicians do not understand, or have a misconception of, the reasons for a local society grievance committee and how it functions.

To put it bluntly, the grievance committee, by trying to mediate differences between a physician and a patient, undertakes a job which should be taken on by the physician himself. Obviously, this can't always be done because of personalities, unreasonableness, on both sides, or some other not too important reason.

The physician who has dealt fairly and competently with his patient has nothing to fear from a grievance committee. He should keep in mind that statistics reveal that the overwhelming number of grievances are due to misunderstandings—misunderstandings which could have been dispelled quickly had frank discussion been possible and actually undertaken.

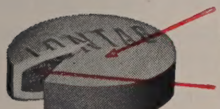
Because so many cases referred to a grievance committee are settled in a manner satisfactory to both patient and physician, the physician should be glad that a mechanism of this kind has been established. Without it, many misunderstandings

X-RAYS SHOW HOW ONE PYRIBENZAMINE® LONTAB®

relieves allergy all day or all night

The unretouched X-ray films show how Lontabs release medication in the digestive tract. So that the prolonged erosion of the Lontab core could be visualized by X-ray, subject was given 10 Lontabs, each containing 100 mg. of a radiopaque substance in place of Pyribenzamine.

With its unique formulation, the Pyribenzamine Lontab not only relieves allergy symptoms promptly, but sustains relief as long as 12 hours.



Special outer shell releases 33 mg. Pyribenzamine hydrochloride within 10 minutes.

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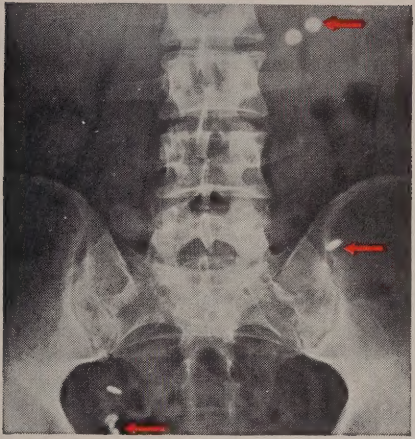
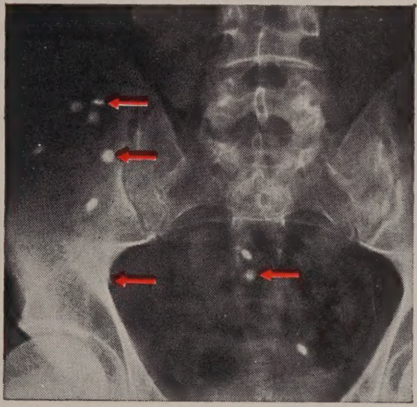
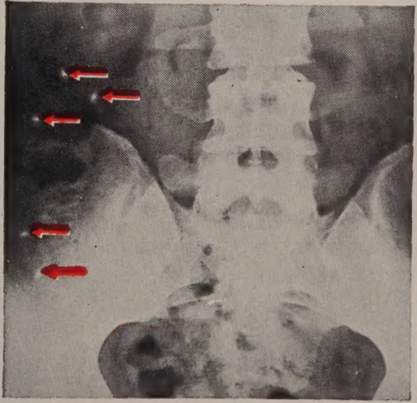
2 hours Lontabs are in the stomach and small bowel. Release of core substance is well under way.



4 hours Lontabs are in the ileum and cecum as core has steadily eroded.



8 hours Lontabs are still visible as substance of core continues to be released.



would never be clarified, resulting in the compounding of bitterness on the part of the patient and often the spreading of unfounded detrimental charges concerning the physician.

CIVIC ENTERPRISES AND MEDICAL ETHICS

How would you answer this question: May a physician permit his name to be used in connection with civic enterprises (e. g., subscription to building funds, season concert series, community fund activities, etc.)?

Here's the way the Judicial Council of the AMA answered it:

"The Judicial Council, at a recent meeting, approved the following comments expressed by Dr. George F. Lull, Secretary of the Association, in answer to a request similar to the above:

" 'I believe it is an excellent thing for physicians to take part in civic enterprises. I think we have gone the other way and held ourselves aloof so long that we are not considered part of the community in many places. It is my personal opinion that our public relations can be improved by each individual physician's activities, since the people who come in contact with him usually judge all physicians by his standards.'

"The Judicial Council does not believe that the use of a physician's name in connection with a civic project should, in itself, be considered contrary to the Principles of Medical Ethics."

DO THE SPORTS EVENTS IN YOUR AREA HAVE PROPER MEDICAL SUPERVISION?

Interscholastic athletics are about to reach their seasonal peak in all corners of Ohio. Therefore, it would be timely for all County Medical Societies to take a direct interest in what goes on in their communities.

In other words are the interscholastic sports activities—the intramural programs, for that matter— in county under proper medical supervision? If not, why? Has the medical profession indicated a willingness to cooperate with the school authorities on this? Have the school authorities asked for and welcomed the help of the medical profession?

These are questions which should be asked and answered in each Ohio community. They imply big responsibilities on both the medical and teaching professions.

The Committee on Injury in Sports of the American Medical Association states that the athlete has the right to expect good health and medical supervision.

The committee has explained what it means by good medical care in the following language:

"Good medical care includes, first, a thorough preseason history and physical examination. Many of the sports tragedies which occur each year are due to unrecognized health problems. Medical contraindications to participation in contact sports must be respected.

"Second, a physician present at all contests and readily available during practice sessions. It is unfair to leave decisions to a trainer or coach as to whether an athlete should return to play or be removed from the game following injury. In serious injuries the availability of a physician may make the difference in preventing disability or even death.

"Third, medical control of the health aspects of athletics. In medical matters, the physician's authority should be absolute and unquestioned. Today's coaches and trainers are happy to leave medical decisions to the medical profession. They also assist in interpreting this principle to students and the public."

LOCAL AREAS MUST SOLVE POOR RELIEF PROBLEM

In quite a number of counties, officials are having trouble in carrying on an adequate poor relief program. The medical parts of such programs are being drastically cut—medical fees reduced, ceilings put on hospital payments, authorizations reduced to a minimum.

The solution lies in digging up more funds, primarily from local general funds or through local special levies.

Poor relief is financed from four sources: a 1 per cent public utilities excise tax; a .65 per cent public utilities excise tax; a legislative appropriation from the state General Revenue Fund, and, in some communities, locally-raised funds appropriated by local governments. Few cities or counties have been using locally-raised funds so long as their share of the excise taxes, plus state "matching," is sufficient to meet obligations.

The local areas are reaping the whirlwind. In good times, the money from the state was adequate or almost adequate for poor relief. So, little if any money from local general funds had to be used. The people didn't have to dig into their jeans for poor relief money—the state paid the bills. Now it's different. Relief rolls have increased. There has been no increase in state money.

It's high time that local areas put their houses in order on this matter of financing poor relief. In the end, the people in each community have some obligation and must assume some responsibility for problems which are local in scope.

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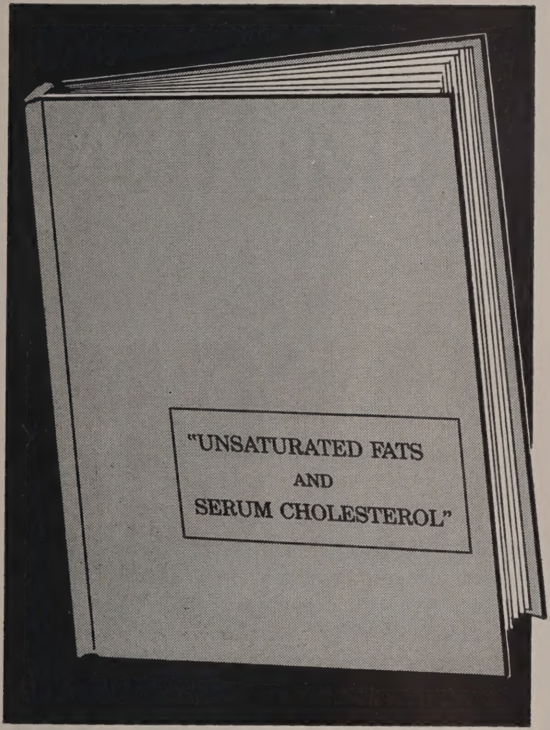

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*Chappel, C.C., J.A.M.A., 162: 1414, (Dec. 8) 1956

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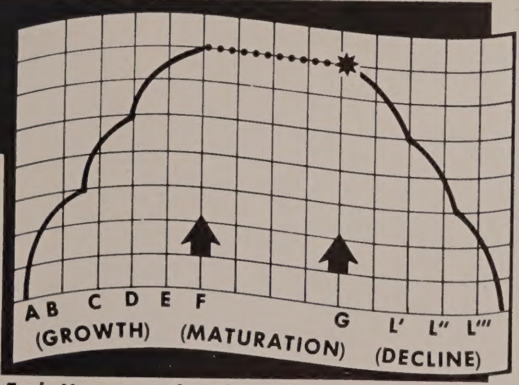

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Usual adult dosage is 2 capsules q.i.d.

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For the treatment of moderately acute infections in infants and children, the recommended dosage is 1 teaspoonful per 15 to 20 lbs. of body weight per day, administered in 2 to 4 equal doses. Severe or prolonged infections require higher doses. Dosage for adults is 2 to 4 teaspoonfuls 3 or 4 times daily, depending on the type and severity of the infection.

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70 YEARS OF SERVICE TO THE MEDICAL PROFESSION

Age 65 Is Not Retirement Age for Many Workers, Study Shows

Large numbers of people in our country continue in gainful employment beyond their 65th birthday, it is reported by statisticians of the Metropolitan Life Insurance Company.

According to estimates by the Bureau of the Census, in March of last year more than half of the male population in the age group 65-69 was still in the labor force; even at ages 70-74, the proportion was practically two fifths, but at ages 75 and over it was only one sixth. The proportion of women in the labor force at the older ages is much lower.

Farm workers show a greater tendency to work beyond age 65 than do those in non-agricultural industries. Consequently, men and women gainfully employed on farms constitute an increasingly large segment of the working population at these ages. While only one tenth of males in the age range 14-64 are engaged in agriculture, the proportion is nearly one fourth at ages 65-69 and almost one third at ages 70 and over.

The majority of older employed persons work full time, the proportion of full-time workers being two thirds for the men and more than half for the women.

"Older workers drop out of the labor force for various reasons," the statisticians conclude. "Many retire voluntarily or because they have reached mandatory retirement age. Pension plans, Social Security, and life insurance benefits have made it possible for an increasing number of people to retire. Since the incidence of disabling disease rises rapidly with advance in age during later life, failing health and physical disabilities are among the major reasons for older workers leaving the labor force."

Ask AMA Help on Nursing School Accreditation

The American Hospital Association House of Delegates has adopted a resolution which would explore the possibility of establishing an independent joint commission on accreditation of hospital schools of nursing. The resolution as adopted said:

"To request the National League for Nursing and the American Medical Association to join the American Hospital Association in establishing as rapidly as feasible an independent joint commission on accreditation of hospital schools of nursing, to be composed of these and possibly other groups, in order to spread the responsibility and financing for the accreditation program more fairly among those who benefit from the services of graduates of hospital schools of nursing."

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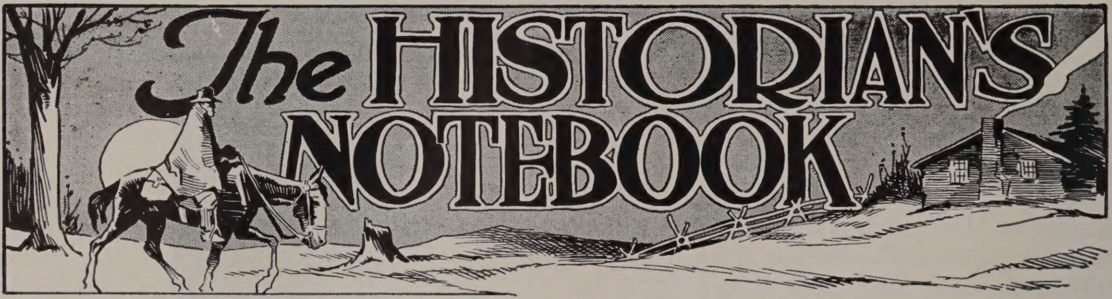

Dr. Mary Edwards Walker (1832-1919); Charlatan or Martyr?

LINDEN F. EDWARDS, Ph. D.

PART II

(Concluded from September Issue)

ALTHOUGH Dr. Walker spent most of her postbellum life on L Street N.W., near the corner of Tenth, in Washington as a registered practitioner of medicine she never established a practice as extensive as she enjoyed at Rome, New York. In September 1866 she sailed for Europe where for a year she visited hospitals and gave lectures to large audiences in London, Manchester, Glasgow and Paris on her favorite topics of dress reform, woman suffrage, capital punishment, the evils of strong drink, the tobacco vice, and the prevention of infanticide. Inasmuch as she was said to be only a mediocre speaker it is likely that the main attraction to her lectures was her garb, the American reform dress as she called it, which on these occasions usually resembled a full dress suit, including a high hat and cane and white gloves. While on this lecture tour she once lectured to a full house in the great St. James Hall in London and was presented to Queen Victoria.

After her return to this country she continued to give lectures, published an occasional article in magazines and wrote two books, one entitled *Hit,* published in 1871 and the other entitled *Unmasked or the Science of Immortality,* published in 1878. For a time she held a clerkship in the Department of Interior and was once appointed to a clerkship in the Treasury Department but her appointment was never confirmed because of objections raised by other women in the department on account of her mode of attire. She received a slight army pension which supplemented her income from medical practice and lectures and in 1890 she inherited the family farm at Oswego, New York, which she managed for a time. At the homestead she conducted for a short time a sanitarium for consumptives and a school for the prevention of this disease on plans which she originated but finances prevented her from carrying through her project.

The Author

● **Dr. Edwards, Columbus, is Professor of Anatomy, The Ohio State University College of Medicine.**

Throughout her entire career she devoted her life to the cause of woman's rights and the emancipation of her sex, although she was usually not in sympathy with her contemporary woman's suffrage proponents and she in turn was not popular with them.

Her Career in the Nation's Capital

Dr. Walker was a familiar figure at the Capitol building in Washington where she spent a great deal of her time lobbying for bills in behalf of her sex and for other reforms. During the 1870's she abandoned her Reform Dress and adopted full masculine apparel consisting of striped trousers, a stiff-bosomed white shirt, frock coat and a high silk hat but with long curly hair. Her one concession to femininity was her long curls, which she claimed she wore so that everybody would

---

A paper read at the meeting of the American Association for the History of Medicine, Williamsburg, Virginia, May 8, 1957.

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Cured	172 (80%)	148 (89%)	71 (88%)
Improved	28 (13%)	8 (5%)	7 (9%)
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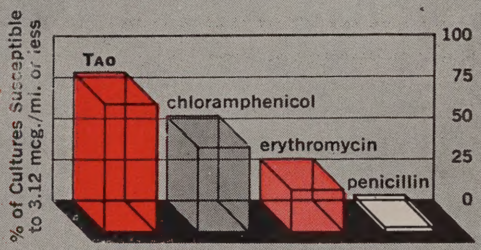
Types of infecting organisms: The majority of identified etiologic microorganisms were Staph. aureus and Staph. albus. Tao has its greatest usefulness against organisms such as: staphylococci (including strains resistant to other antibiotics), streptococci (beta-hemolytic strains, alpha-hemolytic strains and enterococci), pneumococci, gonococci, Hemophilus influenzae.

even against resistant staph[1,2]. . .

Per cent of "antibiotic-resistant" epidemic staphylococci cultures susceptible to Tao, erythromycin, penicillin and chloramphenicol.[1]



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REACTIONS:

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Total—9.2% (20 out of 217)	Total—0.6% (1 out of 167)
Skin rash—1.4% (3 out of 217)	Skin rash—none
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There was complete freedom from adverse reactions in 94.5% of all patients. Side effects in the other 5.5% were usually mild and seldom required discontinuance of therapy.

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Dosage and Administration: Dosage varies according to the severity of the infection. For adults, the average dose is 250 mg. q.i.d.; to 500 mg. q.i.d. in more severe infections. For children 8 months to 8 years of age, a daily dose of approximately 30 mg./Kg. body weight in divided doses has been found effective. Since Tao is therapeutically stable in gastric acid, it may be administered at any time, without regard to meals.

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References: 1. English, A. R., and Fink, F. C.: Antibiotics & Chemother. (Aug.) 1958. 2. English, A. R., and McBride, T. J.: Antibiotics & Chemother. (Aug.) 1958. 3. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy (Aug.) 1958. 4. Celmer, W. D., et al.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 476.

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know she was a woman. However, she betrayed her feminine vanity on one occasion when, according to the account, she had her picture taken laid out as if dead with her clothing fastidiously arranged and flowers scattered about because she wanted to know how she would look when she passed away.

The story goes that whenever a new guard was employed at the Capitol he was informed not to show concern when he saw what looked like a little old gentleman with long hair skipping out of the Ladies' Room, since it would be "Dr. Mary," as she came to be known. Her insistence upon her constitutional right to wear men's clothing made her the butt of many jokes, exposed her to many indignities, including arrests, and greatly overshadowed her career as a physician and champion of woman's rights.

It must be admitted that she was an opportunist, as evident by her eagerness to join the Woman's National Dress Reform and Suffrage movements, which, of course were not original with her, being phases of the great era of reform that set in about the middle of the 19th Century. One wonders if her decision to visit Europe was not arrived at because of her desire to emulate Dr. Elizabeth Blackwell who had previously toured the British Isles and France.

Her battles with what she called the evils of nicotine and intemperance are other examples of her eagerness to climb aboard the bandwagon of reform. That she succeeded in attracting attention by her efforts is shown in the illustrated weeklies which delighted in depicting her dressed like a man and in the act of knocking a cigar from the mouth of an amazed male by means of a rolled-up umbrella she carried for that purpose. She claimed that Col. Chester Allen Arthur, later the President, twice proposed marriage to her but that she declined because he used tobacco.

It is said that her army career and her rich experiences abroad, during which she received much publicity and attention, turned her head and aroused her egocentric tendencies. She evidently lacked diplomacy and was quite outspoken. She criticized Susan B. Anthony and other popular leaders of the American Woman Suffrage organization, as a result of which that organization ignored her for many years, and at one time, it is said, she was even barred from the convention hall because of her attack on these leaders. In spite of her lineal qualifications she was unsuccessful until 1913 in becoming a member of the Daughters of the American Revolution.

Notwithstanding her eccentricities and strong determination of character, she was nevertheless sympathetic and understanding. It is claimed, for example, that she once sheared her curls and sold them to aid a woman who was financially in need and that once after having a man arrested for jeering at her, moved by pity, she paid his fine. While in Washington donating her services toward the war effort during the 1860's she founded a Woman's Relief Organization, the object of which was to befriend women who came to that city to visit their soldier relative or sweetheart and had no place to stay. She once told about working far into the night helping to write transportation orders on furloughs of New York soldiers to enable them to return home to vote in an election. During her career as a general practitioner at Rome, N. Y., she exerted her efforts for the establishment of a Foundling Hospital in New York City where unmarried women could have their babies and during the 1890's she founded a woman's colony called "Adamless Eden."

Her Impoverishment and Death

According to one of her admiring biographers, Dr. Walker's really worth-while claims to a notable place in history have been mostly ignored and that "the amount of good done by this little woman will never be known, most of it was unrecorded except in the hearts and minds of those she helped." It is sad to relate that eventually Dr. Walker became impoverished, due to her declining income from medical practice, and her small government pension which did not keep her from faring badly. She unsuccessfully besought Congress to award her an additional $2,000.00 for services rendered during the Civil War and finally she had to resort to appearing in dime museums for her livelihood.

Present-day accounts of her career continue to be published occasionally in newspapers, magazines and journals. One of the striking features revealed in reading these sketches chronologically is the growing tendency of writers to be less critical of Dr. Walker's whims and more charitable in depicting her life-long struggle for the emancipation of her sex. That her efforts in this struggle were not in vain are evident at every voting booth in this country, at every factory where women are employed and on every street corner where women attired in slacks, Levi's and Bermuda shorts are common sights.

Although little reliable information is extant concerning Dr. Walker's success as a medical practitioner, reportedly she was as skilled as her male contemporaries in amputating limbs, suturing incisions and alleviating suffering. Her death occurred at the age of 87 in Oswego, N. Y., on Feb. 21, 1919, as a result indirectly of a fall on the Capitol steps in 1917.

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(1) Marangoni, B. A.: Am. Pract. & Digest Treat. *8*:1959, 1957.

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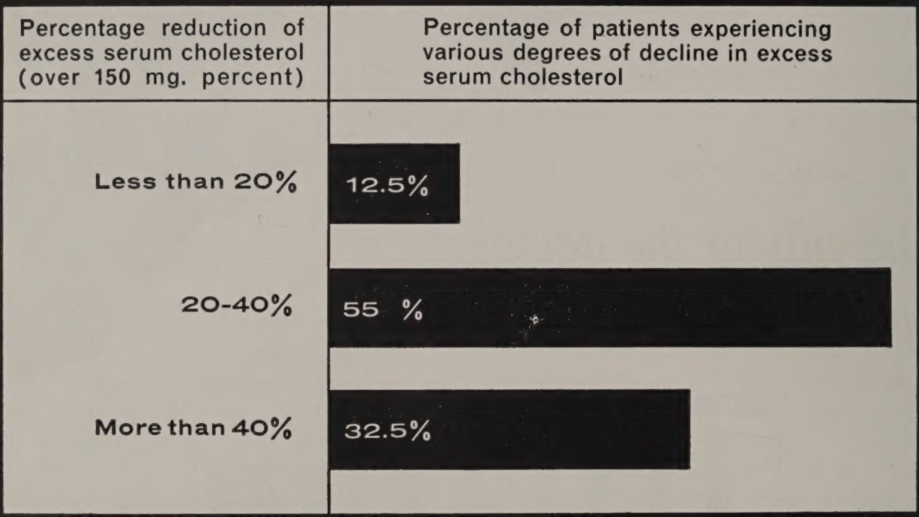

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JONATHAN FORMAN, M. D., *Editor*

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An Evaluation of the Franklin County Cancer Survey Project*

ZEPH J. R. HOLLENBECK, M. D., and JOHN C. ULLERY, M. D.

CLINICAL experience and research in therapy of cancer of the female genitalia have given us a tremendous store of knowledge in methods of application of the various forms of treatment. And yet, when we consider all cases of the most common cancer of the female genitalia —cancer of the cervix—more than 60 per cent of them do not live five years. It is a universally known fact that the earlier in the disease that adequate therapy is carried out, the better are the results.

It is our belief that every woman should have a pelvic examination and a vaginal cytology study at least once every year. I think that the results of the survey presented here will substantiate an even stronger conviction in this belief. This county-wide survey project, using the Papanicolaou smear as a screen test, has been in operation in Columbus (and Franklin County), Ohio, for the past two years. This has been a cooperative study by the Department of Obstetrics and Gynecology and the Department of Pathology of The Ohio State University and under the sponsorship of the National Institutes of Health, Bethesda, Md.

A similar survey has been in progress in Memphis, Tennessee, for the past four years and in other cities for varying lengths of time. In the report of Erickson[1] of the Memphis study, the first 70,000 examinations revealed 527 carcinomas or an incidence of 0.75 per cent (1 in 143). In the Columbus survey, we have found 205 carcinomas in 59,712 examinations or an incidence of 0.34 per cent (1 in 290).

The Authors

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Cancer of the female genital tract seems more prevalent in Memphis than in Columbus. The possible reasons for this will not be discussed here, but it is a startling fact that in Columbus, Ohio, one in every 290 women examined had a cancer of the internal genital tract.

The material studied has come from three sources. There have been 90,786 specimens received of which 66,392 (73 per cent) have come from the offices of private physicians, 8,108 (9 per cent) from the cancer survey project clinic, and 16,286 (27 per cent) from other clinics.

Method of Procedure

The method of making the test is simple and painless. The material from the posterior vaginal fornix is removed with an aspirator and placed on a glass slide. This is covered with another slide, and the two are slid apart. The second specimen is prepared after the vaginal speculum is in place by scraping the area around and in the external os of the cervix with a tongue depressor or a wooden scraper designed for this purpose. The material obtained is placed on the slide, and the slides are fixed and transported to the laboratory in a mixture of equal parts of 95 per cent alcohol and ether.

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*From the Department of Obstetrics and Gynecology and the Department of Pathology, The Ohio State University. Presented before the Section on Obstetrics and Gynecology at the Annual Meeting of the Ohio State Medical Association, April 15, 1958, Cincinnati, Ohio.

In the Columbus study the "aspiration only" method is being used with a control run by a designated few physicians who are using both the aspiration and scrape. Of the 90,786 specimens approximately 13,150 were aspirations and scrapes; the remainder were made by aspiration only. Eighteen (18) patients with cancer were found on positive scrape smears that were negative on aspiration. This certainly emphasizes the value of the scraping test and substantiates Cuyler's[2] work.

In applying this test in your own practice, your cytologist may report his findings in one of three ways: by class, by cytology or by interpretation.

Classification of Papanicolaou Smears

Class	Cytology	Interpretation
I	Normal	Negative
II	Atypical, No Evidence Malignancy	Negative
III	Suspicious, Suggestive-Not Conclusive	Suspicious (Positive)
IV	Strongly Suggestive	Positive
V	Conclusive of Malignancy	Positive

The suspicious or positive smear demands an adequate biopsy of the cervix, preferably by cold knife conization, a dilatation and curettage and an adequate pelvic examination under anesthesia. It must be emphasized here that this test is not infallible, and a negative report in the face of symptoms or positive, clinical findings means absolutely nothing. A patient presenting a suggestive history or suspicious or presumptive findings must have adequate biopsy and examination, regardless of the outcome of the smear. This sequence of events, symptoms with negative smear, usually occurs in endometrial cancer, and this fact has been frequently overlooked.

We must also remember that a positive smear is by no means an indication for therapy. Definitive cancer treatment must be initiated only as a result of a positive biopsy.

In two years, from May 1, 1956 to May 1, 1958, there were 205 cancers of the female genital tract found in our survey of 57,712 women. The various types of carcinomas found are as follows:

May 1, 1956 to May 1, 1958

Carcinoma in situ of the cervix	81
Carcinoma of the cervix	94
Carcinoma of the endometrium	26
Carcinoma of the vagina	3
Carcinoma of the ovary	1
Total	205

Management and Therapy

One of the valuable results of this survey has been the revelation of the various types of management and therapy to which these 205 patients have been subjected. It is of spcial interest to note that there could be no delay, in the institution of therapy, attributed to physician or patient except in three instances of carcinoma in situ of the cervix which were lost to follow-up by patients moving away from the county.

The reader will disagree with some of the methods of therapy as have those of us who have conducted this survey. Definitely, some of the methods are not acceptable and even contraindicated. The majority of the patients have been treated by their own physicians in various Columbus hospitals, and a lack of standard and/or conventionally accepted therapy is evident.

The following tables list the treatment of the 205 cancer patients:

Treatment — Carcinoma in Situ of the Cervix

Total hysterectomy	54
Amputation or cervicectomy	8
Conization	6
Biopsy—cold knife	6
Cobalt 60 and total hysterectomy	1
Cauterization	1
Wertheim hysterectomy	1
Observation (pregnant)	1
None (lost)	3
Total	81

Treatment — Carcinoma of the Cervix Stage I

Cobalt 60 and x-ray	17
Radium and x-ray	8
Radium	19
Cobalt 60 and Wertheim hysterectomy	13
Wertheim hysterectomy	8

X-ray	2
Cervicectomy	2
Total hysterectomy	7
Trachelectomy and x-ray	1
Total	77

Treatment — Carcinoma of the Cervix Stage II

Cobalt 60 and x-ray	8
Radium and x-ray	2
Total	10

Treatment — Carcinoma of the Cervix Stage III

Cobalt 60 and x-ray	2
Radium and x-ray	3
Total hysterectomy	1
Total	6

Treatment — Carcinoma of the Cervix Stage IV

No treatment	1

Treatment — Carcinoma of the Endometrium

Cobalt 60 and total hysterectomy	12
Radium and total hysterectomy	3
Total hysterectomy	10
Wertheim hysterectomy	1
Total	26

(In all but three cases of total hysterectomy, bilateral salpingo-oophorectomy was known to have been done.)

Treatment — Carcinoma of the Vagina

Wertheim hysterectomy and vaginectomy	1
Radioactive gold seeds	1
X-ray	1
Total	3

Treatment — Carcinoma of the Ovary

Exploratory laparotomy and radioactive colloidal gold	1

Two cervical stump cancers were found within a year after subtotal hysterectomy had been performed elsewhere for uterine fibromyomata. There seems little doubt that these patients had their carcinomas at the time of the initial surgery. No biopsy of the cervix or curettage had been performed at the time or prior to the time of hysterectomy.

Importance of Early Diagnosis

Most of the tumors found in this survey were clinically unsuspected (clinically suspected 42 or 20 per cent), but to appreciate the full and tremendous value of the routine Papanicolaou test in detecting 175 cancers of the cervix (of a total of 205 carcinomas), it is well to remember again the International Clinical Classification of Cancer of the Cervix. Stage 0, microscopically no invasion (intra-epithelial); stage I, limited clinically to the cervix: stage II, extending beyond the cervix but not to the lateral pelvic wall (may also involve the upper one third of the vagina): stage III, extending laterally to the pelvic wall (or extending below the upper one third of the vagina): stage IV, with distant metastasis (or a frozen pelvis or bowel or bladder fistulization due to tumor).

The 175 cervical cancers found by this survey were classified clinically as follows:

Stage 0	81
Stage I	77
Stage II	10
Stage III	6
Stage IV	1
Total	175

To further appreciate the value of the Papanicolaou smear we must look at our present results of therapy. These statistics from the Department of Obstetrics and Gynecology of the Ohio State University compare favorably with nationwide and world-wide publications of survival rates.

Five Year Survival

Stage 0	96.2%
Stage I	81.4%
Stage II	48.5%
Stage III	21.4%
Stage IV	2.5%

With these survivals of the various clinical stages of cervical cancer in mind, let us now compare the difference between the registrations in the Tumor Clinic at the Ohio State University Hospital 10 years ago with the cases found by means of a mass survey during the year just past.

1947	Stage	1957
0%	0	38%
14%	I	48%
41%	II	5%
41%	III	7%
4%	IV	2%

To portray this graphically, the incidence of carcinoma in situ of the cervix is noted in figure 1.

The number of cases of stage 0 cervical carcinoma during the years 1947 to 1956 follows generally the increase in the total number of cervical carcinoma cases registered. The time of the institution of the cancer survey project is indicated by the arrow (1956). The 325 per cent increase in the detection of this early and easily curable lesion is almost fantastic. As is evident, earlier lesions *are* being found by cytologic examination.

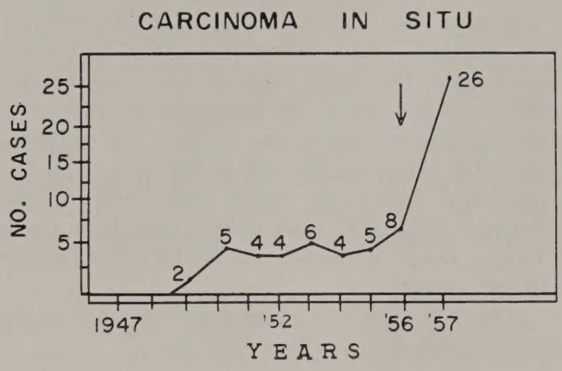

FIG. 1. Carcinoma in situ of the cervix. Registered in University Hospital, 1947 to 1957.

Summary

The objectives of this study and the important conclusions to be drawn from such a mass survey are set forth in previous communications.[3, 4] There are some which bear repetition here.

The aspiration and scraping techniques are suitable for large-scale screening. The scraping method will divulge invasive tumors of the cervix as well as in situ cancer that may be missed by aspiration alone. Both should be used. Neither is diagnostic but merely point the way for further tissue diagnosis by biopsy.

Once the diagnosis is made, no delay may be tolerated in the establishment of adequate and complete therapy. This study emphasizes the lack of uniformity in the application of standard methods of treatment of pelvic malignancy. This is particularly true in cancer of the cervix.

Cervical carcinoma has three clinical characteristics that are extremely important in appreciating the value of the Papanicolaou smear test. First, it is, by far, the most common cancer of the female genital tract. Second, relatively good results are obtained if adequate treatment is instituted early. Third, with this method it can be detected earlier than other carcinomas of the female genitalia.

This test can be applied to the practice of anyone who treats women. Let us help in the reduction of the present-day 60 per cent mortality from cancer of the cervix.

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Underlying Psychological Problems Often the Cause of Dyspareunia

Dyspareunia can often be prevented. Shortly after it occurs, it can be alleviated by relatively simple measures. When it is of long standing, it may tax the ingenuity and patience of the physician. When it follows episiotomy or pelvic repair, it may be embarrassing to the physician who performed the operation. When the condition does not respond to the measures herein outlined, the doctor should suspect underlying psychological problems.

Some women utilize even minor vaginal irritations as an excuse to evade their marital obligation. I recall an old maid who married a successful small businessman in order to quit her disliked job. All was well for two years, then I saw her with the complaint of a vaginal irritation. Examination revealed senile vaginitis and marked vaginismus. Topical estrogen and self-dilatation overcame these, then she developed trichomonas in the estrogen stimulated vagina. This was cleared up but she still protested that her problem was unrelieved.

Review of her domestic history elicited the fact that her husband had recently had a severe illness which depleted their savings. Because of his illness he lost his business and she had had to go back to work to support both of them. I advised her that I could offer no more help. She then developed bladder urgency and frequency and consulted a urologist.—Roland E. Bieren, M. D., Falls Church, Va.: *Virginia M. Monthly,* 85:187, April, 1958.

Staphylococcal Infections In Maternity Units

Staphylococcal infections in the nursery as well as in other areas of the hospital have become a major problem. The magnitude of these infections is such that maternity units in some hospitals have had to be closed by health authorities. To date, we have seen very little of this problem in Connecticut. Baldwin *et al* and Shaffer *et al* have shown that permanent carrier personnel have frequently been the source of an epidemic.—C. E. McLeod, M. D., and A. F. Turano, M. D.: *Connecticut Med.,* 22:596, August, 1958.

Some Pitfalls in Cardiac Management

MAURICE A. SCHNITKER, M. D.

IN this discussion about some pitfalls in the management of cardiac disorders I am not including the pitfalls of ignorance, but I want to take into consideration errors both of omission and commission. They can be many, and I shall try to categorize some of them. They are not necessarily the result of ignorance, but rather, because of the pressure of time, they occur often due to lack of attention to details. Both diagnosis and treatment of cardiac disease present such pitfalls.

Diagnosis

In order to treat any patient reasonably well, a proper diagnosis must be made. It has been well said, *first make the diagnosis, then proper treatment usually will follow.* Let us look at a few of the pitfalls in diagnosis of cardiac disease.

It is just as fallacious, and perhaps serious, to diagnose and to treat heart disease when it does not exist (iatrogenic) as it is not to recognize a cardiac disorder, and hence not to treat it, which may be fatal. In the first instance there is "overtreatment"; in the second instance "undertreatment."

In recognizing heart disease, there are several clues that can be very helpful. The first is the presence of cardiac enlargement. *An enlarged heart is not a normal heart.* Murmurs, particularly systolic in time, continue to be confusing to many. In general, a systolic murmur that is of grade 3 intensity, or louder, (based on Levine's classification of 1 - 6) usually means organic heart disease. There are exceptions, such as with anemia, or with thyrotoxicosis, and if they can be ruled out, the above principle is quite valid.

Under some circumstances, as with asthma, either cardiac or bronchial, it may be difficult at first to decide whether the heart is implicated or not. Unless the patient is in acute pulmonary edema, which should be obvious, another rule of thumb is to listen beneath the clavicles. If one hears the same rales and rhonchi in the subclavicular areas of the chest as one hears at the bases, one is dealing most likely with bronchial asthma. If the subclavicular areas are relatively clear, the condition is more likely congestive failure, or so-called cardiac asthma. Occasionally both may be present, chronic bronchial asthma with cor pulmonale and cardiac failure. If the facilities are available, a test of venous pressure and circulation time, rather easily done, can help to differentiate the two. And of course if cardiac failure is present it should be treated.

The Author

● Dr. Schnitker, Toledo, is President of the Ohio State Heart Association; Director of Medicine and Chief, Medical Service, St. Vincent's Hospital, Toledo.

It has been my experience that careful observation of the ocular fundi will sometimes show slight distention of veins (over and above the 3:2 ratio of veins to arteries) early in congestive cardiac failure, even before there appears to be significant venous distention in the neck.

The appearance of arrhythmias may be an early clue to cardiac disease. In a normal sized heart, without murmurs, occasional extra-systoles, paroxysmal auricular fibrillation or paroxysmal auricular tachycardia may have no serious significance. Extra-systoles may mean more in an enlarged heart, and paroxysmal auricular fibrillation should make one look even closer for mitral stenosis, or hyperthyroidism.

Symptoms may be pitfalls, too, in the recognition of heart disease. Often one of the earliest symptoms, yet most difficult to evaluate, is fatigue. When an older person complains of noticeable ease of fatigue, after anemia and other obvious causes are ruled out, think of early cardiac insufficiency. Sometimes a brief therapeutic test with digitalis is warranted, what Christian used to call "tonic doses."

Cough, particularly when supine, is frequently an early symptom of congestive failure. As has been re-emphasized recently concerning cough with attention to cancer of the lungs, with a cough think also of early pulmonary congestion due to cardiac insufficiency.

Extra-systoles, too, are not always benign. The skipped beats of which the patient complains may be forerunners of auricular fibrillation and early congestive failure. Coupling, in the absence of digitalis, usually means cardiac disease in my experience.

Dyspnea is such a relative thing that it may be

Presented before the Southwestern Ohio Society of General Practice, under the auspices of the Greater Cincinnati Area Heart Association, Cincinnati, Ohio, January 19, 1958.

difficult to evaluate. I do not make a diagnosis, but I keep seriously in mind conscious shortness of breath on two flights of 7 steps each, or less, as suggesting cardiac failure.

Systems Review

As I watch interns and residents begin to work on our medical service, perhaps the greatest pitfall of all, particularly in relation to diagnosis of cardiac disease but in all other disease states as well, is the failure to take any, or an adequate systems review in the history. In our program we teach it early, because if one does not learn to take a proper systems history then, one never does it and hence one never makes full and complete diagnoses. All too often as the present illness and past history are taken, a familial history is "glanced over" and the doctor hastens into the physical examination.

A neglect of a systems review, to "cut corners," usually to save time, leads to two serious consequences: (1) Missing causative phenomena, and (2) missing associated or other diseases. Concerning the first, to name but a few, if one asks about spontaneous epistaxes, frequent sore throats, or joint pains, or St. Vitus dance, one can often uncover a background of rheumatic fever, when in the past history the patient has denied rheumatic fever by name. Or, symptoms of "kidney trouble," or albumin, or nocturia, or episodes of burning on urination, may uncover renal disease as a background for hypertension one finds. Further, a history of recent tooth extraction, or operation on the gastrointestinal or genito-urinary tracts may lead one to the possibility of subacute bacterial endocarditis in the patient with valvular or congenital heart disease, fever and malaise.

Concerning the second, the missing of associated or other diseases, in older people, and particularly in those with coronary artery disease, one should look for diabetes mellitus. One misses entirely such symptoms as polydipsia, polyuria, pruritus, etc., unless a systems review is taken; yet, those may be late symptoms, or may not occur at all. The systems review further may bring out giddiness or occasional loose stools, which may develop earlier than the classical diabetic picture of polydipsia and polyuria. Unless one elicits symptoms of nervousness, sweating, palpitation, or husky voice, or dislike of warm or cold weather, or dry skin in a systems review one may overlook entirely the possibilities of hyperthyroidism or myxedema, and their associated cardiac conditions.

As you well know, anemia can be quite a burden to the heart. As Dr. Sturgis of Ann Arbor has shown,[1] the commonest cause of anemia is due to blood loss, and perhaps the most common of occult causes of blood loss is rectal hemorrhoids. The patient states "they bleed only occasionally," yet I have seen anemias with red blood cell counts under 3 million, when no one recognized this source of bleeding. And it is only through a careful systems review, that requires at the most 10 minutes, that these things are detected.

Other Clues

The pitfalls of electrocardiography in diagnosis is a subject in itself, so I shall mention only a few things. The greatest pitfall, as I see it, is reading too much into the tracing. Electrocardiography is invaluable, however, and a tracing usually should be taken. It matters a great deal who interprets the tracing. It is good discipline to try to determine the nature of a cardiac arrhythmia at the bedside, and it may be just as serious a pitfall not to get an electrocardiogram.

Recently I have seen two patients, who, to all intents and purposes at the bedside had auricular fibrillation. On the basis of a ventricular rate over 100, both had been given extra doses of digitalis. More careful scrutiny of the electrocardiogram revealed the presence of auricular tachycardia with block, which usually is caused by digitalis intoxication. That it may not always be due to digitalis was shown by the fact that the first patient improved on more digitalis; the second patient died very shortly thereafter.

At this point I should also like to inject a thought concerning a "cardiac examination." Time and again, doctors, as well as patients, want "just a cardiac examination," by which they mean auscultation of the heart and lungs, a blood pressure determination and an electrocardiogram. They seem to forget that the circulation is distributed throughout the entire body, and the heart must supply that entire circulation. Clues of cardiovascular disease may be found anywhere in the body. Hence a cardiac examination requires a good general examination.

I have dwelt at some length on diagnosis in the pitfalls of cardiac management to point up two important premises: (1) that a good cardiac evaluation of a patient means a good general examination including a systems review and (2) that the more accurate and complete a diagnosis, the better is the treatment apt to be, with fewer mistakes.

Therapy

In turning now to pitfalls in treatment of cardiac disorders, I should like first to mention the *medical paradox,* a situation not rare in medical practice. This refers to conditions in which one may have very similar symptoms, and signs, from "too much" as well as "too little." For example, compare the symptoms of anemia and polycythemia vera. Both have similar fatigue, palpitation, headache, blurred vision, dyspnea, weakness, tinnitus, and tingling of extremities in their listed symptoms. On casual inspection the patients may not look too differently. Another example is hyperthyroidism and myxedema. Both may have nervousness, palpitation, dyspnea, edema and anemia. Of course there is a striking difference in appearance between exopthalmic goiter and advanced myxedema, but in the forme fruste varieties with such symptoms, it may be difficult to differentiate between the two.

Digitalis Paradox

But the principal example of medical paradox I wish to emphasize in our topic is the striking similarity in many respects between the patient who has had too much digitalis and the one who has had too little. Both can have dyspnea, even orthopnea, anorexia, nausea and vomiting, distended neck veins, rapid heart rate, enlarged and tender liver, pleural effusion, ankle edema, and extra-systoles, even bigeminy. In my experience, the failure to appreciate this medical paradox is an important cause for the overdigitalization of so many patients with heart disease.

With known auricular fibrillation, if the ventricular rate is over 100, generally the patient has not had enough digitalis provided you have ruled out (1) myocardial infarction, (2) hyperthyroidism and (3) primary or metastatic tumor of the heart, in all three of which the fibrillation may not respond well to any doses of digitalis. In the patient with sinus rhythm, and apparent cardiac failure, if the foregoing symptoms are known to have been present before digitalis was instituted, and with the drug there has been a lack of response with mitigation of symptoms, failure to induce diuresis, or to relieve dyspnea, there is probably under-digitalization. If one can feel satisfied that the above signs and symptoms appeared after the digitalis was started, there is probably over-digitalization.

If in doubt the electrocardiogram can be very helpful, remembering (1) that signs of digitalization in the ECG does not mean necessarily that the drug should be stopped; it does mean to "beware" and not to push the drug and (2) the electrocardiogram under digitalis can mimic almost any cardiac disturbance. Then if one is still in doubt, better to continue a maintenance dose, or even to stop the drug for two to three days and use the auxiliary measures, diuretics, correction of electrolytes, etc., under careful observation.

One might raise the question at this point, *when to digitalize?* When there is cardiac enlargement, easy fatigue and some dyspnea, a few basilar rales even with no ankle edema,—I believe digitalization is indicated. What is more, once a patient is digitalized usually maintenance dosage should be continued. If one waits to digitalize until there is overt evidence of failure, prominent distention of neck veins, many rales, even pleural effusion, and 3 and 4 plus peripheral edema, much valuable time has been lost.

Digitalis and Myocardial Infarction

In the patient with recent myocardial infarction, however, with tachycardia and a few rales at the bases, I do not digitalize because I expect some tachycardia from the irritable injured heart muscle and some rales from weakened heart muscle. Furthermore, a few years ago Katz[2] of Chicago demonstrated that if one routinely digitalizes patients with myocardial infarction the average mortality rate rises. In such cases one can concentrate on diuretics, a low salt diet, sedatives and the rauwolfia derivatives (for bradycrotic effect) and when digitalis is frankly indicated after myocardial infarction, as with auricular fibrillation, or with overt failure, it should be given but with caution.

Two other situations in which a therapeutic test with digitalis may be justified are (a) acute nephritis with edema, and (b) chronic bronchitis with emphysema and early (difficult to detect) cor pulmonale. Years ago Longcope[3] and more recently Murphy[4] have shown that practically 90 per cent of patients in the first category have, by careful measurements, evidences of some cardiac failure and should be digitalized. In the second group if it is decided to give digitalis, it has been our experience that small doses of digitalis are tolerated well and bring the best results.

Finally, Altschule[5] of Boston demonstrated an interesting thing several years ago that has not become widely enough known, namely, that many patients, to do best on digitalis, should be re-digitalized once, sometimes twice a year, by giving added doses of digitalis for three to four days at a time.

Now as to the choice of drug to use. With digitalis it is still the best policy *to choose two or three drugs, learn how to use them, and stick to them.* For the average case, powdered leaf is still among the best. Generally it is tolerated better by older people than are the purified glycosides. Since the powdered leaf is rather long acting, it is well to have on hand, and to know how to use, a short-acting preparation, such as Lanoxin®, and an intravenous preparation, such as Cedilanid.® In my opinion the intravenous use of digitalis is much overdone.

I believe digitalis intravenously may be used

(a) in acute pulmonary edema when the patient has had little or preferably no previous digitalis and (b) in cases of auricular flutter where no digitalis has been given within the past week, both rather rare circumstances because usually someone has given the patient some form of digitalis. Generally the drug given by mouth is sufficient, and if the patient is comatose, or is vomiting, intramuscular digitalis works very well. I am not recommending the use of acetylstrophanthidin to determine whether a patient is digitalized or not.

Diuretics and Electrolytes

Other treatments to supplement the use of digitalis in heart failure, such as the low sodium diet and diuretics, both the mercurials and the various carbonic anhydrase inhibitors and sulfonamides are producing pitfalls in therapy. Not long ago, before Dr. Christian died, a point had been reached in the study and treatment of cardiac failure, with the renal factors and electrolytes, to prompt him to remark that "It is beginning to look as though the heart may have nothing to do with cardiac failure."

Both diet and diuretics are sometimes used too little, more often used too much. That is, the low-salt syndrome, refractory states of failure, marked weakness, prostration and even death are becoming iatrogenic. We have had to learn that there is no one digitalizing dose for all patients. Now we have learned that mercurial diuretics are ineffective when used daily, and that if one uses a mercurial and a sulfonamide diuretic together, the one may check the action of the other with little or no diuresis resulting. And we have also had to learn that one can dehydrate a patient too rapidly as well as too much. These are all pitfalls to look out for. The major advances in diuretic drugs have produced less toxic agents, and much more effective ones than we used to have. So, unless the situation is an urgent one, good results are still obtained by oral digitalization of the patient over two to three days, and using, as necessary, a low sodium diet, with diuretics once or twice a week.

Another splendid advance has been a better understanding of fluid and electrolyte balance in diseased states and particularly in cardiac failure. At the same time it has opened another area for pitfalls in therapy. In the first place major electrolyte disturbances can result from too aggressive treatment; then the mistake is made of treating the electrolytes instead of the patient. I have seen more than one patient die with perfectly restored electrolyte balance by the usual tests. We do have to pay attention to them, the restoration of electrolyte balance may be lifesaving, but disturbances of sodium, potassium, chloride and calcium can be a part of the dying state, a problem not yet studied sufficiently. A few years ago Proger[6] studied the electrolyte patterns of several patients dying with cancer, and several cardiac patients who had been treated very conservatively by slow and properly maintained digitalization, with diuretics only once or twice a week, and found the electrolytes in all of them depressed; restoration of the electrolytes did nothing to alter their downhill course.

Sedation

Oversedation is another common pitfall in therapy. We prescribe sedatives to allay anxiety and to help make the patient comfortable. The patient often asks for more to escape reality. Then the intern and the nurse prescribe more so as not to be bothered during the night. All this adds up to slowed respiration, which may be harmful to the cardiac, with disturbed appetite and digestion and micturition, slowed venous circulation with resulting thrombophlebitis and pulmonary embolism, and sometimes a hastening of death. In such cardiac situations as acute pulmonary edema, or acute myocardial infarction, morphine, subcutaneously or even intravenously if necessary, is still the best drug to use.

Then there is the question of bed rest. We prescribe it for rest, but is it always so? It may be a two-edged sword. I have often told patients "seven days in bed makes one week (weak) regardless of how you spell it."

Let us stop to consider some of the hazards in the pitfall of too much bed rest. They may include constipation, distention, urinary retention, anorexia, bed sores, muscle wasting, cramps, phlebitis, negative nitrogen balance, loss of calcium and occurrence of renal calculi and mental depression. The patient's reaction to the strictness with which some cases of coronary thrombosis are treated may be summarized well by a friend's remark, "Go home some evening, doctor, have your wife tie your hands behind you, have her feed you, then have her bring you the bed pan from the ice box."

With other things being equal, it is well to allow the patient to dangle and to sit up as soon as he is able, and particularly if he wants to. If prolonged bed rest is necessary, particularly with a cardiac situation present, we have found it helpful to use the Wilkins' regime[7] of applying elastic stockings or wrapping the legs firmly with an Ace bandage, to prevent the occurrence of thrombophlebitis. If phlebitis does occur, we use the Homan's regime of placing the patient in the Trendelenberg position, with three pillows under the head, which appears to lessen the incidence of pulmonary embolism.

Diet

Diet can be used very effectively in cardiovascular disorders. We starve the patient to lower the blood pressure, and we use a low sodium diet to get rid of edema and these measures work. But there are also several pitfalls. We are apt to overlook general dietary and vitamin deficiency often associated with chronic illness.[8] There is the economic factor. A chronic illness, such as cardiac disease, can be a severe financial burden to the breadwinner of the family. This results in less food, food of poor quality and improper balance.

Such chronic illnesses can produce a depression with resulting loss of appetite. Passive congestion of the gastrointestinal tract may cause more anorexia and indigestion with the further avoidance of food. When we add to that sometimes overdosages of drugs—digitalis, sedatives, ammonium chloride, etc. — these things can all lead to hypoproteinemia, anemia, more edema, loss of weight, and vitamin deficiency. The treatment for this pitfall is obvious once one thinks about it, with the attempt to relieve anxiety and despair, the elimination or change of anorexic drugs, the use of adequate proteins, vitamins of the B complex and proper ambulation.

Another important pitfall in therapy is the accumulation of drugs. It is a good rule to *review the drug schedule of treatment at periodic intervals.* Drugs pile up so easily, before one knows it the patient may be receiving 10 or 12 drugs, when two, three, or four properly thought out, would be ample. Then one always should know the contents and actions of each drug that one prescribes. In other words, *know what you are giving.*

The last pitfall that I should like to emphasize is the failure to recognize associated disease. It is a good maxim *to keep looking for other things, particularly those that are treatable.* Anemia due to blood loss is a good example. Long-standing anemia is a considerable load to the heart. Try to find the source of bleeding, correct it if possible, then build up the blood, and the results can be excellent.

In every patient that you see with angina pectoris, ask yourself four questions concerning factors in the pain:

(1) Is there anemia?

(2) Is there a thyroid disturbance, hyperthyroidism or myxedema?

(3) Is there aortic valve disease, stenosis or insufficiency?

(4) Is the pain all due to coronary artery disease?

The first two, one often can do something about. Keeping hyperthyroidism constantly in mind makes it much easier to recognize; the same with myxedema. *If you do not recognize myxedema in the patient the first time you see him you may follow that patient for years and never recognize it.*

Other Correctable Conditions

One should add to these the so-called "reversible forms" of heart disease, amenable to specific therapy. Anemia and thyroid disturbances have already been mentioned, but there is constrictive pericarditis, beriberi, and the whole host of congenital lesions that respond to specific surgery. And it is just as important to recognize, and to treat adequately, subacute bacterial endocarditis with a persistently negative blood culture.

To summarize briefly, there are pitfalls in overtreatment and in undertreatment of patients with cardiac disease, so one might reverse an old adage which says, "there are tricks to all trades"; in the practice of medicine "our trade is all tricks."

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Mercury Poisoning Outbreak In Ohio

An outbreak of mercury poisoning occurred in a small plant in Ohio in which classical symptoms of the disease were observed. Of the 36 employees who had the symptom "sore mouth," 22 had tremors or "shakes"; others had difficulty in writing and personality changes. The use of the Cornell Medical Index Questionnaire was effectively applied in the investigation.

There was marked contamination of the working environment and of the clothes of the workers to a mercury-copper amalgam tamping compound. The air concentration ranged from 1.0 to 7.5 mg. per cubic meter. Exposure was by inhalation, ingestion and absorption.

Blood and urine levels of mercury showed no direct correlation to symptoms of mercury poisoning. Higher levels in urine were generally found in persons with long exposure.—Dorothy Benning, R. N. M. S. W., Ohio Department of Health, Columbus: *Industrial Med. & Surg.,* 27:354, July, 1958.

The Problem of Pertussis

SAMUEL SASLAW, M. D., Ph. D., and CHARLES F. WOOLEY, M. D.

The Authors

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THE successful application of pertussis vaccines was first introduced by Sauer in 1933.[1] Despite the general availability of an adequate prophylactic agent for over two decades, whooping cough still presents one of the most serious of the acute communicable disease problems.

During the period from 1945 through 1956 a total of 46,131 cases and 457 deaths (1 per cent) were reported in Ohio (Table 1). These figures actually represent the trend rather than the true case rate since many cases are not reported, and deaths may be reported as the complication rather than the basic disease. During this same period 343 patients with pertussis were admitted to University Hospital (Table 1).

The higher mortality of 6.4 per cent (22 deaths) in the hospitalized group is not unexpected since the more actuely ill, and younger children with complications were referred to the hospital. Pulmonary complications, particularly bronchopneumonia or atelectasis were observed in 44 per cent; central nervous system complications such as encephalitis or hemorrhage occurred in 9.5 per cent. Nutritional complications due to vomiting occurred in 6 per cent of our patients. From the economic standpoint alone one can't overlook the fact that the average hospital stay of our patients was 12.1 days or a total of 4,150 hospital days.

As can be seen in Table 2, 79, or 23 per cent, of our admissions consisted of children three months of age or under; 142, or over 41 per cent, were not older than six months of age. In many communities immunization is not begun until the child is at least six months old. A total of 210, or 61 per cent, of the patients were under one year of age. It is remarkable to note that none of our patients had had complete pertussis immunization. In fact, most of the children had had no immunization, whatsoever. In reference to mortality, 19 of the 22 deaths occurred in children under two years of age, while 12 of these were actually under one year of age. Table 3 describes in more detail the 22 fatal cases. It is of interest to note that 14 of these patients died within 24 hours of admission after arriving at the hospital in a moribund state. Only one Negro mortality occurred, but in this particular study does not suggest a lower incidence since only 35 (10 per cent) of our admissions were Negroes, which is in proportion to the 10 to 12 per cent of non-whites in this area.

These observations tend to re-emphasize [2,3,4] the serious import and high incidence of pertussis and is not peculiar to Ohio. This situation is particularly distressing when methods are available for improving the problem. Under ideal conditions when all of the members in a stable community seek and receive early immunization for their children, exposure to whooping cough is minimized considerably. However, when there is a shifting population with an influx of people neglectful of immunization opportunities, the dis-

TABLE 1.—*Incidence of Pertussis in Ohio and University Hospital 1945-1956.*

	Ohio			University Hospital		
		Deaths			Deaths	
Year	Morbidity	No.	%	Morbidity	No.	%
1945	7,742	106	1.37	30	2	6.7
1946	4,207	58	1.38	8	1	12.5
1947	10,451	83	0.79	59	2	3.4
1948	2,919	52	1.74	40	7	17.5
1949	3,696	29	0.78	35	2	5.7
1950	7,334	46	0.63	38	4	15.8
1951	2,127	17	0.79	34	1	2.9
1952	1,554	12	0.77	14	0	0
1953	1,437	17	1.18	13	0	0
1954	2,258	17	0.75	21	3	14.5
1955	1,885	15	0.79	37	0	0
1956	521	5	0.96	14	0	0
Totals	46,131	457	0.99	343	22	6.46

From the Department of Medicine, The Ohio State University.

TABLE 2.—*Pertussis Morbidity and Mortality According to Age—University Hospital 1945-1956.*

Age	Morbidity No.	Morbidity %	Mortality No.	Mortality %
1 month	16	4.7	2	12.5
2 "	32	9.3	1	3.1
3 "	31	9.0	2	6.4
4 "	19	5.5	1	5.3
5 "	22	6.4	0	0
6 "	22	6.4	2	9.1
7 - 12 months	68	19.8	4	5.9
13 - 24 "	75	21.8	7	9.3
>2 years	59	16.9	3	5.2

TABLE 3.—*Pertussis Deaths—University Hospital, 1945-1956.*

Patient	Home	Year	Age	Sex	Color	Hosp. Days	Complications
1.	Cable	1945	6 mo.	F	W	9	Bronchopneumonia, encephalitis
2.	Columbus	"	1 yr.	F	W	1	Dehydration, bronchopneumonia
3.	Lynchburg	1946	7 mo.	M	W	1	Encephalitis, Dehydration
4.	Columbus	1947	2 yr.	M	W	1	Bronchopneumonia, cerebral edema
5.	Groveport	"	4 mo.	F	W	12	Bronchopneumonia, acute laryngeal edema, cerebral anoxia
6.	Washington C. H.	1948	7 wks.	M	W	5	Bronchopneumonia, atelectasis
7.	West Jefferson	"	19 mo.	M	W	1	Bronchopneumonia, atelectasis
8.	Washington C. H.	"	3 mo.	M	W	3	Aspiration pneumonia, atelectasis
9.	Columbus	"	3 yr.	M	W	1	Dehydration, cerebral edema, pulmonary edema
10.	Lancaster	"	14 mo.	F	W	1	Encephalitis, bronchopneumonia
11.	Jackson	"	11 mo.	F	W	1	Bronchopneumonia
12.	Lancaster	"	2 yr.	M	W	1	Atelectasis, bronchitis
13.	Columbus	1949	13 mo.	M	W	8	Atelectasis, bronchopneumonia, adrenal hemorrhage
14.	Columbus	"	3 yr.	F	W	1	Emphysema, bronchitis, cerebral edema
15.	Doanville	1950	3 mo.	F	W	1	Bronchopneumonia, cerebral edema
16.	Columbus	"	18 mo.	F	N	1	Bronchopneumonia, atelectasis
17.	"	"	6 mo.	F	W	3	Dehydration, uremia
18.	Chillicothe	"	3 mo.	F	W	6	Malnutrition, atelectasis
19.	S. Solon	1951	9 mo.	F	W	2	Bronchopneumonia, cerebral edema
20.	Galena	1954	21 mo.	F	W	1	Bronchopneumonia, cerebral edema chickenpox
21.	Frankfort	"	1 mo.	F	W	1	Bronchopneumonia
22.	Jackson	"	5 wks.	M	W	1	Bronchopneumonia

ease is presented a good opportunity to attack a susceptible population.

Control Principles

The following principles are suggested to decrease the morbidity and mortality due to pertussis:

1. Since most infants are susceptible from birth, all infants should be actively immunized as early as possible, starting at two to three months of age.[5, 6, 7]

2. Immediate passive protection with hyperimmume serum of any nonimmunized infant exposed to pertussis.

3. Follow through with boosters at the indicated intervals, especially in preschool children.

4. An ever present alertness by health departments and physicians of various communities as to the immune status of their community and particularly of newly arriving families.

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Accidental Death Statistics During Past Decade

Accidents, which have claimed an average of 93,000 lives annually over the past ten years, are responsible for 6 per cent of all deaths in the United States. Among persons one to thirty-six years of age, they are a leading cause of death.

Accidents play an important role in the mortality of the aged, a fact that may be overlooked because of the high incidence of chronic diseases in that group.

Among persons past age sixty-four, accidents cause between 25,000 and 26,000 deaths annually. Aging persons account for one out of every four accidental deaths.—*Minnesota Med.*, 41:535, August, 1958, as abstracted from *Patterns of Disease.*

Further Observations of Climatic Treatment of Hay Fever And Asthma with Special Reference to Florida

FRANK C. METZGER, M. D.

AN article of mine entitled "The Climatic Treatment of Hay Fever and Asthma, with Special Reference to Florida" appeared in *The Journal of the American Medical Association,* January 7, 1939 issue. An abstract was published by Dr. Morris Fishbein in his syndicated column. The Florida State Department of Health sent copies to people inquiring about asthma in Florida.

For some years I noted a definite decrease in patients sent to Florida for "climatic cure of asthma." In the past five years, however, there has been a steady increase in the patients I see who are told to come to Florida to get rid of their asthma or hay fever.

My experiments and observations since 1939 have caused me to revise my ideas on certain phases of this subject and have strengthened the others.

Since moving to another climate is a very serious matter, I feel that a review of this subject would be of value.

It seems obvious that if any change of climate were advocated for the cure or alleviation of *any* disease, one should first ascertain whether or not the natives of the new climate suffer from the disease in question. As far as allergy and its manifestations are concerned, I know of no such place. I have seen cases of asthma and hay fever in people who lived in Alaska, Africa, Hawaii, the Phillippines, China and Japan. I felt that no one should have asthma, especially of the inhalant variety, in the desert. But two women patients stated they had their first attacks of asthma when they were half way across the Sahara Desert. Four soldiers had severe asthma in Kunching, China, two had it in Death Valley.

Many allergic Floridians go to Arizona. Some get better, some get worse, the majority have no change. But I have had over a hundred allergic patients who came from Arizona to Florida seeking climatic relief. Some got better, some got worse and again the majority experienced no change. So we find that heat and cold, height or depth of the land, moist or dry climates are not the panaceas they are popularly supposed to be for asthma or hay fever.

Some Better, Some Worse. Why?

This being true, how then do we explain why some get well and some get worse? Many of these cases we can explain on a pure allergic basis; i. e., exposure or nonexposure to their specific allergens in the new place. The patient may inadvertently go to a place where his specific allergens are absent or at a minimum. If a person sensitive to ragweed moves from Indiana, Ohio, or any state with a high ragweed count, to Florida he should become almost symptom-free and be among those who "got better." The east coast of Florida is practically free of air-borne pollen. If, however, he made the opposite move and went from Florida to a midwestern state, he would be among those who "got worse."

The Author

● Dr. Metzger, well known allergist of Tampa, Florida, is a graduate of The University of Cincinnati College of Medicine who, before specializing in allergy, was in general practice in Waverly, Ohio (1916-1921).

Obvious Conclusions Are Frequently Erroneous

Many times the move is given credit it does not deserve. An eight year old boy with asthma and hay fever, lived in Fort Myers, Florida. The ragweed counts in Fort Myers then were 8 to 12 granules per cubic yard per day. At the height of the ragweed season, September 15, I received a letter from his mother. She stated she had taken the boy to Georgia to "get him away from the ragweed."

The ragweed counts in this city of Georgia were 500 to 600 granules per cubic yard per day. She reported the boy was much better." The facts were that neither from his history nor tests was he sensitive to ragweed pollen. His father was an alcoholic and his home life in Fort Myers was not good. I heard later from patients living in Fort Myers that the mother was advising all asthmatics from that area to go to Georgia, since the climate there had "cured her son." And, thus, the ball keeps rolling. Doctors must have facts to combat such ignorance.

If asthma and hay fever were all caused by the same allergens, this problem would be simpler and

I could then conceive of a place where they were absent. But, it just isn't that way.

I have seldom seen an allergic individual sensitive to only one thing. I have seen many in whom one allergen was predominate, in which cases, avoidance or treatment for that one allergen resulted in freedom from symptoms. This would be one factor in the patients who see no change in their condition, i. e., they didn't get away from *all* their allergens. House dust is a sensitizing agent in a large per cent of sufferers from asthma and allergic rhinitis. In any climate people live in houses. Who then would expect them to fall into any other category than those who get no benefit from the change? In a warm climate people do get out of the house more hours per day, the windows are open, the dust is not so concentrated, hence their exposure is lessened. This would account for some cases who are better but not entirely free of symptoms.

In the past 18 years my experience from a clinical angle has not borne out my former conclusions; i. e., that our house dust was more potent than that found in northern homes.

Changes in Florida

There have been certain changes in Florida lately which have altered the picture I gave in 1939. Florida has grown immensely in population. Hence more houses, more yards, more roads, and since ragweed and cultivated grasses follow civilization, our pollen counts, especially for ragweed, have steadily increased and we now find that whereas in 1939 only individuals highly sensitized to ragweed and grass had trouble from these courses, in 1957 even those moderately sensitive have symptoms during the blooming period of ragweed and grass.

Thousands of acres in Florida are now fenced for cattle raising purposes and many have been planted to new grasses. Wild grasses are poor pollen producers, the cultivated grasses produce more. Along the fences ragweed grows where formerly in these uncultivated spaces no ragweed was found. I have not, as yet, observed any giant ragweed in South Florida. I now find that I have to increase the concentration of treatment doses for ragweed and grasses. I note no increase in the number of patients sensitized to tree pollens. In south and central Florida the oak tree is the predominant one whose pollen is sufficiently "widespread and abundant" to cause much trouble.

The number of manufacturing plants has increased bringing with them the usual smoke, fumes and dusts. The employees are exposed to occupational dusts and frequently those dusts, fumes and smoke affect patients living close to these plants. This factor, however, is very small compared to most northern cities, but in 1939 it could be ignored almost completely. Now some consideration must be given to it.

Longevity

Another factor has entered the picture. I refer now to the increase in longevity. The number of patients one sees who are past the four-score-and-ten span is increasing. In these cases one rarely sees pure, uncomplicated asthma or hay fever. Along with the allergy comes cor pulmonale, coronary thrombosis, arthritis, loss of elasticity of the musculature in the lung, emphysema, decreased resistance to infections and, last but not least, set convictions as to the action of various drugs and methods of treatment.

Convictions in elderly people are, in my experience, practically impossible to change, and so the psychological element of suggestion wipes out the use of many valuable drugs and methods. Most of these patients are on small fixed incomes and no honest physician can say anything to them to allay their fear of inflation.

In my former report I devoted one paragraph to the neurogenic or psychic element. My experiences have led me to believe that this element is accountable for a much greater part in the picture of results obtained than I formerly thought. I am struck with the frequency and poignancy with which they speak of their former homes, the friends and relatives they have left, the jobs or farms they have abandoned, their terrific disappointment that the climate had not stopped their asthma or hay fever as they had been led to believe it would. What are they telling me? They are indicating that they have exchanged the security idea of home, friends and familiar surroundings for the insecurity idea of a new home, strangers and unfamiliar sights and sounds. Do these things cause depression, anxiety and bodily feelings of discomfort and loss of vitality? The psychiatrists I consulted have without exception said yes, and more in older people than young ones.

That insecurity and anxiety enters the picture of the allergic individual has been quite well established.

Thermal Factors

There is a group where the psychological element helps. This group is comprised of those who are convinced that cold weather is the big or sole cause of their asthma. It is a fact that sudden drops in temperature are accompanied by spells of asthma in some cases. Why, we do not know. Since most people "practice medicine" and reach conclusions as to causes of their asthma, when there is some truth in a given circumstance, this conclusion becomes a conviction, and convictions can become phobias. These people come to Florida or another warm climate. They get away from the physical effect of large drops in temperature and this acts as a defense mechanism.

My advice to physicians advising change of climate for relief of asthma remains unchanged; i. e., determine the allergens active in each given case, ascertain in what places said allergens are absent, diminished, or more easily avoided. To this advice, I now wish to add the following: The psychological effect upon the individual of a change should if possible be evaluated, for very frequently it can neutralize the good effect of diminished exposure to specific allergens.

Summary

Some allergic individuals can be helped by change of place. We can increase the percentage in this group if all factors are considered before advice to pursue such change is given.

Acetylcarbromal and Bromisovalum Not Habituating, Study Shows

A comprehensive review of medical literature and 371 case studies showed that two monoureide derivatives of carbromal, namely acetylcarbromal and bromisovalum, are not habit forming whether used singly or in combination. Sedayson® (a combination of acetylcarbromal 150 mg. and bromisovalum 100 mg.) and also acetylcarbromal 300 mg. and bromisovalum 200 mg. tablets, when used in full dosage over long periods of time, were negative as to the criteria of drug habituation.

Daily dosages of 6-8 Sedayson tablets, acetylcarbromal 1.8—2.4 Gm. or bromisovalum 1.2—1.6 Gm. were given. All patients were observed closely during treatment and for an adequate period of weeks after medication was discontinued.

Because of a chemical relationship, the monoureides (carbromal, acetylcarbromal and bromisovalum) have been classified mistakenly as habit forming. However, one cannot predict the physiological action of a drug with any degree of certainty from its chemical structure. Due to the fact that the monoureide sedatives are not habit forming, have no side effects, no hangover and no contraindications, their use in combination is much preferable for continued use as a sedative or somnifacient to the dangerous and habit forming barbiturates.—Abstract: A Comparison of Monoureide and Diureide Sedatives with Respect to Drug Habituation, Untoward Effects and Mortality Rates, Feinblatt, T. M., Feinblatt, H. M., and Ferguson, E. A., Jr., *J. Nerv. & Ment. Dis.*, 125: 335; April - June, 1957.

Selective Readings

The Medical Interview, by Ainslie Meares, M.B.B.S. ($3.50, *C. C. Thomas Publisher, Springfield, Ill.)* It deals with motivation for the interview, the intellectual factors, non-verbal communication, rapport, passivity in the interview, hostility, suggestions in the medical interview, the physical examination, silences. This is a text that is needed in all fields of medicine because medical interviews of this nature form a very large part of medical practice. Unlike medical history taking, on the one hand and the psychiatric interview on the other, the medical interview refers to the discussion which takes place when it is some problem rather than a symptom which brings the patients to the consultation room.

Trace Analysis, by John H. Yoe and Henry J. Koch, Jr. ($12.00, *John Wiley & Sons, Inc., New York 16, New York.)* Presenting papers given at the 1955 Symposium, on the subject, at the New York Academy of Medicine. At a meeting of the scientific advisory board of the Sloan-Kettering Institute the subject of trace elements and the methods of analysis for them was brought up before the board. It soon became apparent that the subject had not received the cooperative effort it deserved as an un-unified field of science. Therefore, the Rockefeller Foundation and the Sloan-Kettering Institute decided to present this symposium in an effort to bring together for discussion different authorities and different disciplines from industry, agriculture, biology and medicine and to consider which of the various techniques would be directly applicable to the research investigation of the Sloan Institution.

New England Hospitals, 1790-1833, by Leonard K. Eaton. ($6.00, *University of Michigan Press, Ann Arbor, Michigan.)* This is a study of the impact of an institution on the people. Horace Mann, John Bartlett, John Adams, John Lowell, Josiah Quincy, and Dr. Eli Todd turned men's thoughts to the care of the mentally and the physically ill. People like the gentle mannered Dr. Jackson considered it their duty not merely to "throw a few pills and powders into one pan on the scales of Fate while Death itself was seated in the other, but to lean their whole weight on the side of Life and shift the balance in favor if it lay in human power to do so." In these early days the hospital was, as it is in our times, an institution devoted to healing the sick, a center of research and learning and a challenge to the architect and the rounds of endless financial and administrative struggles in growth. Dr. Eaton places this development in a cultural perspective.

MATERNAL HEALTH IN OHIO

TOPIC THIS MONTH:

Maternal Deaths* With Postmortem Cesarean Section

THE primary purpose of this column is to present suitable material pertaining to obstetrics as a "refresher" program for the information and education of Ohio physicians who practice obstetrics.

After browsing over the wealth of data contained in the case files of the Ohio Maternal Mortality Study, the chairman of the Committee*, impressed with interesting material concerning *postmortem cesarean section,* desires to present some of the statistics on the subject. This is not to be considered as a personal accomplishment, but rather in a sense of pride focused upon members of the Committee, and numerous other physicians throughout Ohio who have contributed generously to the project, in both time and effort.

Cesarean section has always been one of the most dramatic procedures in the armamentarium of the surgeon. Even more exciting is the same operation which salvages a living infant from its dead mother, although it represents the oldest application of this famous operation.

Background

A moderate amount of material has appeared in the literature concerning this topic. Kelly[1] and co-workers presented an excellent summary of the literature with a history of the operation; they reported 111 successful postmortem cesarean sections from a survey of world literature, and added two cases. DeKruif[2] and associates reported a successful case, and stated that from 1950 to 1954 the Minnesota Mortality Study reported 14 postmortem cesarean sections without the survival of a single infant. Weil[3] et al. (Akron, Ohio) reported four postmortem cesarean sections at City Hospital, with two infants surviving a year or more; two operations were unsuccessful. However, none of these four is contained in the files of our Ohio Maternal Mortality Study, hence they are not listed in the 25 cases mentioned in this article.

The Ohio Study

Since January 1, 1955, when maternal mortality cases were first collected for the Ohio Study,* a total of 408 cases have been compiled to date. Some which were acquired recently have not yet been reviewed by the Committee, hence they are not classified as "maternal death" or "nonmaternal death."

Among the 408 cases, there were 25 postmortem sections, listed in table 1, which resulted in the delivery of nine living infants (including one set of twins.)

If the figures were corrected, omitting the group

TABLE 1. *Fetal Results, According to Length of Gestation, 25 Postmortem Cesarean Sections. Ohio State Maternal Mortality Study.*

Less than 28 weeks gestation: (5)

Case 61—stillborn
" 119—stillborn
" 195—alive, lived 15 minutes
" 231—alive, lived 2 hours
" 256—stillborn, macerated

From 28 to 36 weeks gestation: (5)

Case 79—stillborn
" 137—stillborn
" 159—stillborn
" 172—stillborn
" 225—stillborn

From 36 to 39 weeks gestation: (7)

Case 44—stillborn
" 59—stillborn
" 211—alive, lived 2 hours
" 229—stillborn
" 264—alive, lived 1 hour
" 274—alive, lived 1 hour
" 304—stillborn

From 39 to 40 weeks (term): (8)

Case 9—stillborn
" 76—alive, no follow-up
" 132—stillborn
" 157—alive (twins) & well now
" 164—stillborn
" 193—stillborn
" 194—alive & well now
" 207—stillborn

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*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by official representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

below 28 weeks gestation, there would be 20 postmortem cesarean sections, with a salvage of seven living infants (including one set of twins.) An effort was made to ascertain the condition of the living infants, over a period of time. Of the seven living infants, three have survived and are healthy today, one was impossible to follow-up, and three (from the 36 to 39 week category) died two hours or less after delivery. This indicates a survival rate of 15 per cent of the total possibilities in 20 cases, or three of the seven born alive through postmortem cesarean sections survived two or more years.

The *eight* cases of postmortem cesarean section which salvaged a living fetus (one had living twins) are briefly summarized below, to depict the terminal clinical signs and the cause of the mother's death:

Case No. 195

A 21 year old, white, gravida II, Para I, who died at 26 weeks gestation. Her prenatal care was adequate; she was a known case of Hodgkin's disease, with extensive treatment. Suddenly she developed dyspnea, chest pain, was hospitalized and died. An immediate postmortem cesarean section delivered a living fetus (no weight) which survived 15 minutes. *Cause of death* (no autopsy): cardiac failure; pulmonary edema; Hodgkin's disease. Non-maternal death.

Case No. 231

A 29 year old, white, gravida III, Para II, who died at 26 weeks gestation. Her prenatal care was adequate; she was known to have bronchial asthma. Suddenly she developed dyspnea, cyanosis, "terminal congestive heart failure" and died. An immediate postmortem cesarean section delivered a living fetus (no weight) which survived for two hours. *Cause of death* (no autopsy): Acute bronchial asthma; allergy; circulatory failure. Non-maternal death.

Case No. 211

A 31 year old, white, gravida IV, Para II, abortus I, who died at 36 weeks gestation. The prenatal care was adequate, with prompt treatment of pre-eclampsia; she had had eclampsia with a previous pregnancy. Hospitalized for therapy of progressive toxemia in the 35th week, the patient improved only briefly, then she suddenly convulsed, became dyspneic, cyanotic and died. An immediate postmortem cesarean section delivered a living fetus 6 pounds, 9 ounces, which survived two hours. *Cause of death* (no autopsy): Cardiovascular accident; hypertension; toxemia of pregnancy. Maternal death.

Case No. 264

A 42 year old, white, gravida II, Para I who died at 36 weeks gestation. She received adequate prenatal care. In her third trimester she was treated in the hospital emergency room for a strangulated umbilical hernia; it was reduced after she was admitted to the hospital. Soon she developed nausea, nasal hemorrhage, later abdominal distension, pulmonary congestion and finally generalized rigidity and cyanosis. She died on her 21st hospital day. An immediate postmortem cesarean section delivered a living 6 pound fetus which lived one hour. *Cause of death* (autopsy): Pulmonary infarction; bronchopneumonia; atelectasis. (Case not reviewed.)

Case No. 274

A 30 year old, white, gravida III, Para II who died at 36 weeks gestation. She was a known cardiac case, and received exceptionally good prenatal care with bed rest etc. Suddenly she became dyspneic, was hospitalized and in spite of vigorous treatment she died 12 hours later, in congestive failure. Immediate cesarean section delivered a living fetus (no weight) which survived one hour. *Cause of death* (no autopsy): cardiac failure; rheumatic heart disease. (Case not reviewed.)

Case No. 76

A 35 year old, white gravida VI, Para V, who died at 39 weeks gestation. She was said to have had adequate prenatal care, yet visited her physician only several times; no toxemia was noted, and no laboratory studies were recorded. Admitted to the hospital with dyspnea and profuse sweating, the patient pursued a downhill course and died, apparently of congestive failure; no convulsions were noted. Immediate postmortem cesarean section delivered a 7 pound living fetus which survived (no follow-up since father removed it from hospital). *Cause of death* (no autopsy): Acute cardiac failure; eclampsia (?); myocarditis. Maternal death.

Case No. 157

A 24 year old, white, gravida III, Para II, who died at term. Prenatal care adequate. Last week of pregnancy x-ray revealed twin pregnancy with "interlocking chins"; surgical consultation recommended cesarean. Elective operation scheduled; a low spinal anesthesia of Pontocaine® was administered, and followed by 3 cc. Sodium Pentothal® (1 Gm./20cc), whence the patient's heart and respirations ceased. Oxygen and artificial respiration were administered, and immediate cesarean section delivered living twins, 8 pounds and 6 pounds 8 ounces, which are alive and well in 1958. *Cause of death* (no autopsy): respiratory paralysis during induction of anesthesia for cesarean operation. Maternal death.

Case No. 194

A 27 year old, white, gravida VII, Para IV, abortus II, who died at term. Prenatal care was adequate. Patient began labor spontaneously and was admitted with ruptured membranes. Labor was irregular, not progressive. X-ray studies revealed no gross pathology. Several doses of Pitocin® (½ minim) were administered with no effect, and were not repeated. It was elected to perform a cesarean section but while the operating room was being prepared the patient suddenly became dyspneic, and cyanotic; oxygen was administered on the way to the operating room. Approximately three minutes after death a cesarean section was performed delivering a 6 pound 4 ounce living fetus. The baby is alive and well in 1958. *Cause of death* (autopsy); amniotic fluid embolus, pulmonary; left hemothorax; retroperitoneal hemorrhage; cervical tear. Maternal death.

Comment

It is possible that the living infant delivered in **Case No. 76** is still alive and well, although all efforts to trace the case were futile. Nevertheless, it can be seen that the closer to term the gestation progresses, the better the chance of fetal survival after postmortem cesarean section. However we quite agree with Weil[3] as he states, "Any gestation progressed beyond the 28th week should be given every possible chance of survival." He further states that if signs of fetal life were present shortly before the mother's death, we should assume the fetus is alive and immediately deliver it. "Legally we are not justified in delaying for the purpose of obtaining operative permits."

The circumstances present in **Cases 157 and 194** just prior to death of the mother seemed more or less "ideal" (if that term may be used) for a prompt postmortem cesarean section with fetal survival. On the other hand, it has been pointed out by Kelly[1] (quoting Eastman) that the length of infant survival is profoundly diminished by conditions such as chronic illness or wasting disease of the mother, especially when the terminal events produce cyanosis.

If we shall attempt to save a living fetus from *certain* death within its dying mother, we must make a prompt decision and intervene at once! "Mere statistics should not discourage one from attempting this procedure (postmortem cesarean section) despite most trying circumstances," DeKruif[2]. The seven *living* infants, with three (and perhaps a fourth) surviving and healthy today, out of 20 postmortem cesarean sections in the Ohio State Maternal Mortality Study would certainly indicate that a more favorable attitude should be developed towards this procedure.

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Tolbutamide Compared to Insulin For Diabetic Control

Tolbutamide does not facilitate glucose utilization. It does not directly influence other hormones except the hypoglycemic effect of insulin, nor do other hormones affect it. It is not an insulin substitute and one would wish to determine its ultimate value in diabetic management, because disturbances in fat and protein metabolism, as well as carbohydrate metabolism, are significant defects of the disease. Clinically we measure only hyperglycemia and ketosis, yet we know both protein and fat metabolism are profoundly affected by insulin and lack of it.—Howard M. Hackedorn, M. D., Seattle: *Northwest Med.,* 57:749, June, 1958.

Postural Hypotension

Following surgery, postural hypotension may occur and last for several weeks. However, even though the physiologic changes are profound, readjustments occur in a matter of months with a disappearance of unpleasant symptoms. Response to drugs is more pronounced and sensitive, even with smaller doses.—Peter Hywelris Jones, M. R. C. S., L. R. C. P., Lexington, Ky.: *J. Kentucky State M. A.,* 56:562, June, 1958.

The Effect of Antimetabolites On Embryonic Development

The experiments to date, which are preliminary in nature, have given us experience in the effect of antagonists on enzyme systems important in neural development. By this technique, one may interfere with a known neural enzyme system, study its effects on the developing organism and compare the results with what may be occurring in nature by chance. One may produce an acute dietary deficiency by blocking an essential vitamin during the gestation period of the mother, or for that matter, one may block any known neural enzyme system. In this way one may simulate that which might be occurring spontaneously in nature.

There are many naturally occurring antimetabolites which may be taken in excess amounts during the vagaries of appetite of the mother during her pregnancy to the harm of the growing offspring. Of the antimetabolites under study we know that there are naturally occurring substances antagonistic to the vitamin thiamine, and indole-3 acetic acid is a naturally occurring plant hormone.

By this same technique we are able to study the effect of drugs which are given in treating some disease processes; in this instance, isonicotinic hydrazide used in treating tuberculosis. Moreover, by this technique we can study substances that may be produced within the organism itself and absorbed as a foreign substance such as tryptamine in the colon which is formed by bacterial action.

Of considerable importance is that the amount of any of these substances given to adult animals was so small as to cause no detectable physiological or psychological effects, whatsoever. However, the effects on the embryos, in their development, were devastating.

Continuation of this area of research, then, has for its objective the elucidation of factors which interfere with the normal development of the neural system of the embryo and result in pathological states clinically characterized as mental retardation, cerebral palsy, or convulsive disorder. We have a long way to go but the road looks open and the highway offers excitement en route. —Jacques S. Gottlieb, M.D., Charles E. Frohman, Ph.D., and Joan M. Havlena, M.A.; Detroit: *J. Michigan M. Soc.,* 57:364, March, 1958.

Intestinal Polyps in Children

It behooves all of us to search diligently for possible polyps in any child with blood in the stool, diarrhea, recurrent abdominal cramps or history of mass prolapsing from the anus.—Robert H. Burt, M. D., *Northwest Med.,* 57:1004, August, 1958.

Herpes Gestationis: Report of a Case*

WILLIAM E. SPRAGUE, M.D.

HERPES GESTATIONIS is an uncommon complication of pregnancy. Because of this the author feels that this presentation would be of interest to the medical profession.

The patient, a 23 year old primagravida, had had an uneventful prenatal course until five days prior to her expectant date of confinement, May 8, 1957. At this time she noticed the eruption of small erythematous papules around her umbilical area which became vesicular and spread rapidly over the abdomen within four days.

Blood pressure, urinalysis, and blood count were normal. A diagnosis of herpes gestationis was made. She was placed on Aureomycin® ointment and Aureomycin capsules, 1 four times daily, and advised to keep her fingernails short. The papulovesicular eruptions spread to her back and symmetrically down her legs. She remained afebrile and the fetal heart tones were good.

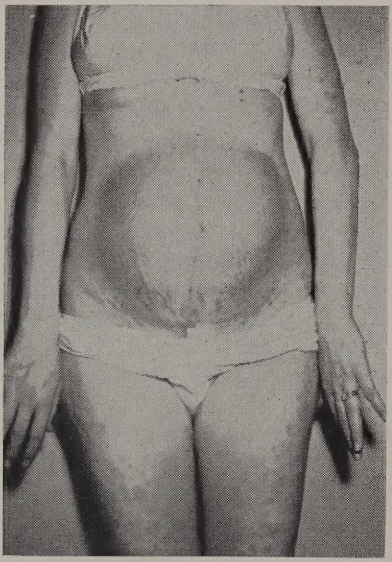

FIG. 1. Patient on second postpartum day showing confluency of lesions over abdomen.

In my review of the meager literature it is reported that although maternal prognosis is good there is some danger to the fetus, perhaps due to a viremia, although the etiology remains obscure. Because of this jeopardy, a medical induction of Pitocin® drip was begun on May 10, and a viable infant was delivered spontaneously nine hours after beginning the induction.

The Author

Dr. Sprague, Athens, is a member of the Obstetrics and Gynecology staffs of Sheltering Arms Hospital, Athens; and Mount St. Mary Hospital, Nelsonville.

Her postpartum course was noted by continual spread of the lesions across her chest, symmetrically down her extremities to her hands and feet. By the fifth postpartum day the entire body was involved with the exception of the face which never became affected. Meticorten® 5 mg. four times a day was begun on the fifth postpartum day. The lesions became confluent first about the abdomen, and gradually throughout the remainder of the body—the lesions first appearing, disappearing first. At 12 days postpartum the skin was completely clear, the disease having lasted for a total of 17 days.

It is to be noted that although the Aureomycin did not halt the spread of the disease, secondary infection was prevented as the patient's course was entirely afebrile and nontoxic. Meticorten was used to prevent any post-herpetic scarring and this too was achieved.

Acknowledgment: Consultation acknowledgment is gratefully made to John C. Ullery, M. D., Columbus, Ohio, and F. C. Prunty, M. D., Parkersburg, W. Va.

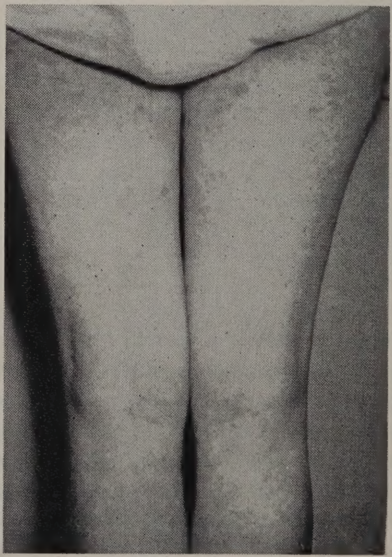

FIG. 2. Second postpartum day showing symmetrical distribution of lesions on posterior aspects of legs.

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*From the Obstetrical Department, Sheltering Arms Hospital, Athens, Ohio.

Developmental Anomalies

A Case Report on Preventable Blindness

WILLIAM H. HAVENER, M. D.

A BLIND EYE is a serious loss to both patient and community. Awareness of the preventable nature of a significant portion of this blindness should help in reducing the incidence of such tragedies. The representative cases to be presented here are selected to emphasize relatively common causes of blindness which can in many instances be averted by proper, timely care.

Case Report

Shortly after birth it was recognized that this 5 year old child suffered from bilateral aniridia. The appearance was entirely typical, with no visible iris in either eye. Absence of the foveal light reflex indicated coexistence of the frequently associated anomaly of macular maldevelopment. Nevertheless, vision seemed quite adequate for the childhood requirements of eating, walking, playing, recognition, etc.

At about the age of 4½ years there seemed to develop a hesitancy in behavior and a reluctance to play with small things. During the following six months this situation became worse and the parents recognized that their child was not seeing as well as formerly. When the child was brought for examination, vision seemed limited to light perception only, the optic nerves were deeply excavated and atrophic, and the intraocular pressure was over 50 (twice normal).

Discussion

The assumption that all developmental anomalies are untreatable and irreversible is certainly unwarranted. Aniridia is a good example of a disorder which requires careful follow-up in order to avoid predictable serious complications. Quite commonly glaucoma develops in association with aniridia. Because of this known association, intraocular pressure should be checked periodically during childhood in such patients. Surgery is frequently quite effective in controlling this type of glaucoma. Failure to detect glaucoma through suspicion and routine tonometry led to the blindness of the aniridia patient described.

Crossed eyes present at birth represent another good example of preventable visual loss. Should the child exhibit preference for one eye, the other, unused, eye may develop severe suppression of vision. Recognition of the monocular nature of this strabismus will present an opportunity to save vision through proper occlusion therapy.

Congenital glaucoma almost invariably leads to blindness unless proper surgery is done promptly. The important thing is recognition of the glaucoma, which is simplified by the fact that these children usually have enlarged corneal diameter (greater than 12 mm.). "Great big pretty eyes" are not good! Often rents occur in the posterior corneal surface and cause the corneas to become quite steamy and opaque. Corneal enlargement or opacity at birth or during childhood should arouse suspicion of glaucoma and indicates prompt care.

The Author

● **Dr. Havener, Columbus, is on the attending staff at University Hospital, and Acting Chairman, Department of Ophthalmology, The Ohio State University College of Medicine.**

Iridocyclitis or chorioretinitis may occur during infancy or even prenatally. Therapy is with mydriatics and steroids just as in adult life, and is often very effective. Mistaking such inflammations for stationary congenital anomalies is possible, and leads to serious neglect. The syndrome of congenital toxoplasmosis with macular chorioretinitis, intracranial calcification, convulsions, and hydrocephalus is well established.

Almost no one realizes that much can and should be done even for the ultimate eye anomaly of anophthalmos or severe microphthalmos. Without the stimulus of an eye, the lids and socket will not develop properly and the cosmetic end result is very poor. Beginning during infancy a plastic prosthesis should be fitted to the eye socket. Gradual enlargement of this prosthesis will result in a fairly normal socket with presentable lids. Surgery on a neglected socket and lids in adult life will never result in as nice appearance as will this early care.

Among the causes of microphthalmos is rubella occurring during the first trimester. Deliberate exposure to German measles during childhood is wise prophylaxis for little girls. Some reports indicate benefit from gamma globulin given a pregnant woman immediately after exposure to rubella.

Retinopathy of prematurity (retrolental fibroplasia) is now well recognized as a defect easily prevented through avoidance of excessive oxygen.

The rare anomaly of galactosuria results in bilateral cataract formation which can be avoided simply by the elimination of milk in all forms from the infant's diet.

In summary, many types of developmental anomalies of the eye benefit from prophylactic treatment and careful observation.

A Clinicopathological Conference

Edited Under the Auspices of the Ohio Society of Pathologists

WILLIAM SINCLAIR, M. D., *President*

Presented by

- **B. K. Wiseman, M. D., Columbus, and**
- **Emmerich von Haam, M. D., Columbus.**

Edited by Dr. von Haam.

Presentation of Case

THIS 25 year old white male entered University Hospital, Columbus, Ohio, with the chief complaint of general weakness. The patient had always been in good health until five weeks prior to admission, when he developed a sore throat and fever. Penicillin brought relief after about one week. His appetite had been poor and he had tended to be constipated since the onset of symptoms. He then developed general weakness, easy fatigability, and his fever and sore throat reappeared. He was reported to have drunk about a pint of tar remover four weeks prior to admission but admitted to no other contact with drugs or chemicals. His urine was reported to have been dark during the last two weeks prior to admission.

His local physician found him anemic and he entered a local hospital, where blood and bone marrow examinations were done. His hemoglobin was 7.8 Gm.; white blood count was 1,950 with 52 per cent lymphocytes, 4 per cent monocytes and 44 per cent neutrophils. Platelets were apparently adequate in number, and his temperature was 102° F. He apparently did not have hepatomegaly, splenomegaly or lymphadenopathy, and he was transferred to the University Hospital. There was no family history of diabetes or tuberculosis. He was a moderate drinker (up to 6 pints of beer daily) and smoked an average of one pack of cigarettes daily.

Physical Examination

The patient was a muscular while male in no distress, alert, and was ambulant on admission; temperature was 100° F., respirations 24, blood pressure 102/54. His skin showed a fine maculopapular rash over the back, but no petechiae, bruises or jaundice. There was no superficial adenopathy. There was no evidence of throat infection; no gingival lesions were noted. His pupils, fundi, ocular movements and visual fields were normal. His lungs were clear to percussion and auscultation.

The heart showed the position of maximal impulse 8 cm. from the midsternal line in the fifth intercostal space. A grade I to II blowing systolic murmur was heard over the pulmonic and aortic areas and showed no radiation; the second aortic sound was greater than the second pulmonic. The heart rhythm was regular. Abdominal examination showed a firm spleen enlarged to 3 cm. below the left costal margin. The liver and kidneys were not palpable and no tenderness or abdominal masses were felt. Bowel sounds seemed normal in quality. The remainder of the physical examination revealed nothing abnormal.

Laboratory Investigations

The hemoglobin was 9.6 Gm., red blood cell count 3.01 million; reticulocytes 0.2 per cent; white blood cells 600 with 10 per cent polymorphonuclear leukocytes, 76 per cent lymphocytes and 12 per cent monocytes; platelets numbered 318,240. No abnormal red or white cells were observed. Hematocrit was 32 per cent; sedimentation rate was 26 mm. in 60 minutes. Bone marrow examination showed an increased cellularity consisting mostly of normoblasts with normal appearing megakaryocytes and small numbers of normal lymphocytes; myeloid elements were sparse and mature granulocytes were inconspicuous.

Tests on blood for specific auto-antibodies against white cells were positive in a dilution of 1:64. Direct and indirect Coomb's tests were negative. Serologic tests for syphilis were negative. The urine had a specific gravity of 1.028 and was negative. Stool was guaiac-negative. The blood urea nitrogen was 22 mg.; blood sugar 122 mg.; van den Bergh direct was 0, indirect 0.5 mg.; thymol turbidity 10 units; cephalin flocculation 2 plus; total serum protein 6.9 Gm. with an albumin/globulin ratio of 3.9:3; serum cholesterol was 122 mg.; sodium, potassium and chlorides were normal; inorganic phosphorus was 5.8 mg., alkaline phosphatase was 1.9 units.

Three 24-hour fecal urobilinogen determinations showed 85 mg., 116 mg. and 250 mg. per total weight. Bromsulphalein test on the sixth day was negative. Heterophil antibody test on the fifth day was positive to a titer of 1:56. Guinea pig absorption was positive in 1:7 dilution. Two febrile agglutination tests for typhoid, paratyphoid and Brucella organisms were negative. Two blood cultures were negative.

Radiologic Studies

Four days after admission radiologic examination showed a normal heart, normal lung fields and a normal upper urinary tract. The examination of the gastroduodenal tract revealed only the presence of a large spleen pressing on the stomach.

Hospital Course

The patient's general condition remained unremarkable during the first six days in the hospital. However, on the sixth day he started to show an afternoon pyrexia and by the ninth day he was having a remittent fever ranging between 99° and 104°, with corresponding rises in pulse and respirations. At this time his total white count was 650 with 30 per cent polymorphonuclear leukocytes, 30 per cent small lymphocytes and 40 per cent monocytes. His red blood cell count was 2.76 million with 1.4 per cent reticulocytes and a hemoglobin of 8.4 Gm. His platelets numbered 193,000.

On the 12th hospital day he was seen by a surgical consultant because of the development of a severe, knifelike pain over lumbar 3 and 4 areas, followed by bilateral lower abdominal pain. No nausea occurred and no shoulder pain was felt. He had a temperature of 104.6° and his abdomen was rigid. His bowel sounds were decreased. The serum amylase was 97 and he had passed three rather loose stools that day. A blood culture was negative, and stools yielded numerous coagulase-positive Staphylococci. An upright film of the abdomen showed many air and fluid levels within the colon and a few within the small bowel. Surgical intervention was not deemed indicated.

At this time he was on erythromycin, 500 mg. four times daily, and 2 cc. of Combiotic® daily from the initial rise of temperature. He was given 3 units of whole blood and 1 liter of dextrose in water. His condition failed to improve and his pyrexia, tachycardia and increased respiratory rate persisted. He became semicomatose, and the jaundice, which had been developing, progressively deepened. During the last three days he vomited small amounts of dark blood and was incontinent of small amounts of tarry stools. He was also coughing up small amounts of blood-tinged sputum. His right chest became dull to percussion posteriorly and breath sounds over this area were somewhat diminished. He expired quietly on his 16th hospital day.

Clinical Discussion

Dr. Wiseman: This is indeed a most fascinating case and I think that if I could team up with a Pinkerton detective I might make better progress. My thinking has chiefly evolved about the possible connection between the tar remover he allegedly drank and the subsequent events. All the tar removers that I know anything about have benzol in them. I don't believe anybody can drink nearly a pint of this liquid without getting some complaints from his stomach and bowels, and there is no statement that he had an acute gastroenteritis. Perhaps he just spiked his beer a little bit with a drop or so of benzol. It is not an uncommon practice to put some ether or other things into your drink in order to get a kick out of it, and you can get a kick out of benzol. As I say, a Pinkerton detective would have been very useful here in hunting down the details in respect to that tar remover.

His difficulty started about two weeks prior to his admission to University Hospital. He had a sore throat and a fever for which penicillin seemed to be helpful. About that time his blood count revealed a marked leukopenia and a moderate anemia. Obviously something was happening to the blood-forming organs at that time, and the lack of sufficient leukocytes I think would account for his fever and the infection of his throat, which was effectively controlled by penicillin. At this time he did not have any enlargement of the spleen, liver or lymph nodes and apparently got over that one episode quite well. He was then admitted to University Hospital for some additional investigation of his blood picture.

Hospitalization

When he entered University Hospital he showed no surprising clinical signs or symptoms except that he did have a palpable spleen extending about 3 cm. below the left costal border. Three centimeters below the costal border may vary a good deal from one person to another, but it would be a spleen that should certainly weigh over 300 Gm. and perhaps as high as 600 Gm. His systolic murmur heard in the pulmonic and aortic areas of the heart was probably a functional type of murmur explainable by his anemia.

His peripheral blood showed a pancytopenia, and his white count was certainly not compatible with life for a very long period of time. But no abnormal cells were seen. The platelets were reduced by about 25 per cent. The bone marrow picture is rather unusual, I think, in view of the pancytopenia of his peripheral blood. It showed an almost specific granulocytopenia. Very few myeloid elements were present, but many nucleated red cells and normal megakaryocytes. I would like to warn you at this point that the bone marrow does not always reflect the true state of hematopoiesis. There are many hematologic dyscrasias in which the marrow appears pretty normal while the peripheral blood reveals severe difficulties in the production of these cells.

With the evidence we have from his peripheral count, we can assume that his marrow also had difficulties in producing red cells and platelets in spite of its normal cellularity with respect to the normoblasts and megakaryocytes. His serum contained specific auto-antibodies against white cells demonstrable in a dilution of 1:64, which is fairly strong by that particular technic. The titers seldom go higher than 1:128, and I would consider a titer of 1:64 quite indicative and reliable.

Afternoon Temperature

In his first six days in the hospital nothing remarkable happened. He then developed an afternoon temperature and a remittent type of fever, and I would rather think that he was again showing signs of a secondary infection due to his very low neutrophil count. His platelets had dropped to 193,000. On the 12th hospital day he had a severe knifelike back pain followed by bilateral lower abdominal pain, which I consider the sort of muscular pain that you see in infections. He was running a pretty high fever and his abdomen then became rigid, probably through muscle spasm or myositis. The surgical consultant felt that he did not have any intraabdominal lesion which warranted surgery.

One wonders about the significance of the coagulase-positive staphylococci found in his stools and what relationship this finding might have to his demise. He had not many signs of an enteritis, but the staphylococci might have played an important part in this man's death in conjunction with his pancytopenia. Then his van den Bergh started to rise and he became rather severly jaundiced and semicomatose.

The question of why he became jaundiced should perhaps not be too difficult to answer. I think that his jaundice was due to liver failure from toxemia. I don't know what the liver might show pathologically, but I expect some changes in the parenchymal cells. There is no reason to believe that he had obstructive jaundice. His platelets got lower and lower and he developed spontaneous hemorrhages in various places including his bowels, and he expired.

I am going to stick to my opinion that the benzol was responsible for this man's fatal illness. But in the differential diagnosis you certainly have to consider other things which would cause a pancytopenia and a collapse of his bone marrow. Of course benzol does cause an aplastic anemia and it does it quite often. There are several kinds of aplastic anemia: those induced by a long list of drugs headed by benzol or compounds with the benzol ring, and the so-called idiopathic aplastic anemia the cause of which is unknown. Our case fits aplastic anemia and the only reason to give it a specific etiological factor here is the rather acute course of the disease. The idiopathic types usually go along for a considerable time. This, however, was rather acute and on that basis alone should be related to some toxic agent.

What about agranulocytosis? Our modern theory about agranulocytosis is that this is an autoimmune type of disease and auto-antibodies have been demonstrated in agranulocytosis of Pyramidon® etiology. I don't believe this is agranulocytosis because all other blood cells almost disappeared from his peripheral blood.

There is a disease known as cyclic neutropenia, in which the neutrophils will disappear, the spleen will enlarge, and the patients will have a lot of fever and a lot of secondary infection. But just about the time you are beginning to worry whether the patient is going to get well or die, the neutrophils come back spontaneously for some unknown reason and all the symptoms disappear. However, this man did not recover but went progressively downhill and died.

Monoblastic Leukemia

In a case like this I always think of monoblastic leukemia. We have had most bizarre experiences with cases of monoblastic leukemia, and I feel quite definitely that individuals have died on our service of monoblastic leukemia in whom only a few monoblasts were present in the bone marrow and none in the blood. I doubt very much the possibility of monoblastic leukemia in this case. I think the bone marrow would be the strongest evidence against it in that there was no mention of immature cells in the marrow.

We come next in our differential diagnosis to our old friend Hodgkin's disease. Hodgkin's disease is the pathologist's trap for internists, as it can have a most unusual clinical course. In a case like this, with fever and some degree of splenomegaly, and with collapse of the bone marrow and pancytopenia, you could never rule out Hodgkin's disease with certainty short of a complete tissue examination of the body. However, patients with Hodgkin's disease usually have a pretty cellular marrow and I think that a collapsed marrow would be the one strong point against Hodgkin's disease. The total course of the disease, lasting some seven weeks from the onset of fever to death, would also be a little more acute than any Hodgkin's disease I have seen. Even the fulminating type usually lasts three months.

The other condition I have listed here is one of the reticuloendothelial diseases. I have mentioned acute monoblastic leukemia, which I think belongs in that general family. There are quite a number of reticuloendothelial abnormalities, as you know. Did he have a reticuloendotheliosis which destroyed his marrow? Again reticuloendotheliosis of any kind except acute monoblastic leukemia usually does not show the fulminant course that this individual had.

So as I look over all possibilities which would be likely to explain this man's death I come back again to the fact that he had been drinking this tar remover and I think the condition that would best fit the course of this man's disease is acute benzol poisoning. In summary then, I would state that my first choice, and really my only choice, of diagnosis would be aplastic anemia caused by acute benzol intoxication. I would put Hodgkin's disease as my second choice, and acute monoblastic leukemia my third choice. However, both diseases seem unlikely for the reasons stated.

Multiple Hemorrhages

Pathologically, this man should show multiple hemorrhages in various tissues because of the low blood platelets, and he ought to show a rather general reticuloendothelial hyperplasia, particularly in the bone marrow, the spleen and lymph nodes, where most of the reticuloendothelial elements are aggregated. I say that because experimental work with benzol poisoning has shown that this drug seems to prevent the reticuloendothelial cells from manufacturing cells which mature into normal blood elements. I think that this patient's bone marrow will be aplastic as far as normal cells are concerned, but will show an increase in reticuloendothelial elements.

I doubt if the autopsy will reveal much infection. This patient was certainly saturated with antibiotics, and we have seen many individuals who die with practically no cells in their blood, but no infection. The patient might have a staphylococcic enteritis, but his protocol does not support that very well. He is probably going to show a toxic hepatitis with degenerative changes in the liver cells. I have no other way to account for his terminal jaundice. As an incidental finding, he may also have some adrenocortical hyperplasia since he received ACTH and most individuals who have been given ACTH show this at surgery or autopsy.

Clinical Diagnosis

1. Fulminating aplastic anemia due to acute benzol intoxication.
2. Generalized reticuloendotheliosis.
3. Toxic hepatitis.
4. Adrenocortical hyperplasia.
5. Possible staphylococcic enterocolitis.

Pathological Diagnosis

1. Toxic necrosis of bone marrow.
    (a) Pancytopenia.
    (b) Hemorrhagic diathesis.
2. Secondary reticulum cell hyperplasia.
3. Adrenocortical hyperplasia.
4. Jaundice.

Pathological Discussion

Dr. von Haam: At autopsy the patient appeared well developed, well nourished and considerably jaundiced. The peritoneal cavity contained 1500 cc. of yellowish, cloudy fluid. Both pleural cavities contained approximately 900 cc. of straw-colored fluid. The heart was of normal size and showed no evidence of gross pathologic change. The lungs appeared partially collapsed and hemorrhagic. The spleen weighed 360 Gm.; it was firm and dark red. The liver appeared grossly normal. The mesenteric lymph nodes were moderately enlarged and firm. The gastrointestinal tract showed extensive submucosal hemorrhages, most noteworthy in the stomach. The adrenals were increased in size and weight and showed a bright yellow cortical tissue. The remaining organs including the brain appeared normal on gross examination.

Microscopic Examination

Microscopic examination of the heart showed extensive reticulocyte proliferation throughout the heart muscle resembling some type of chronic myocarditis. The heart muscle also showed small areas of necrosis, and there were numerous fine petechiae throughout the myocardium. Examination of the lungs showed extensive alveolar hemorrhages and no evidence of any secondary infection. The lung tissue appeared quite atelectatic and the bronchi were filled with a hemorrhagic exudate, suggesting anoxia as the final event.

Examination of the spleen and lymph nodes showed an extensive reticulum cell hyperplasia without much evidence of active hypersplenism. The spleen also did not show extramedullary hematopoiesis. Similar reticulum cell hyperplasia was observed in the liver. The liver cells, however, appeared normal and there was no evidence of any degenerative lesion. Examination of the adrenal glands confirmed the gross diagnosis of adrenocortical hyperplasia. Examination of the bone marrow showed nearly complete necrosis of the areas which were examined. In some sections a few islands of preserved bone marrow remained. There was a focal reticulum cell hyperplasia which was far less than that found in other organs. Examination of the kidneys revealed only parenchymal hemorrhage.

In summary then, we can state that the autopsy findings confirmed almost verbatim Dr. Wiseman's prediction. The only clinical diagnosis which could not be substantiated was that of toxic hepatitis, and I believe that his jaundice was not due to liver injury but to hemolysis of his extravasated blood cells and the transfused blood. We found no evidence of bile stagnation in the liver and his liver function was probably not impaired.

The severe reticulum cell hyperplasia was so impressive that the idea of reticuloendotheliosis was entertained. However, the changes in the bone did not support such diagnosis, and I am in full agreement with Dr. Wiseman that the reticulum cell hyperplasia was secondary to his bone marrow lesion. Complete lack of extramedullary hematopoiesis also agrees with the point he made with regard to the paralyzing effect of benzol upon the maturation process of reticulum cells in benzol poisoning. The absence of any terminal infection in the lungs and in the gastrointestinal tract is remarkable and speaks for the effectiveness of modern antibiotic therapy.

The patient died from the effect of anoxia produced by his anemia, aggravated by severe atelectasis and hemorrhages in his lungs. Most of the accumulation of fluid in the pleural cavities must have been a terminal process since it was not present on x-ray examination shortly before his death.

Cholecystectomy Performed During The Post-Optimal Period

Many surgical writers favor operative intervention within the first 12 to 48 hours following the onset of acute disease. Cholecystectomy is not a procedure to be undertaken lightly in any instance, and the literature warns the unwary about vascular and ductal anomalies of the gallbladder and common duct, and contains treatises on reconstruction of the damaged common duct.

For surgeons who undertake surgery for the relief of acute gallbladder disease, such warnings must be emphasized even more forcefully, and they must be cautioned about the increased hazards of trauma to this area.—J. K. MacGregor, M. D., Mason City: *J. Iowa M. Soc.,* 48:502, Sept., 1958.

Many Factors May Be Accountable in Development of Periarteritis

Previously Rich and his co-workers studied the effects of cortisone and ACTH in rabbits that were sensitized to horse serum and reported a striking decrease in incidence of vascular lesions. Bagenstoss reported temporary relief in human periarteritis nodosa treated with cortisone. Apparently hormonal influences are important in the etiology of both periarteritis and hypertension, but several essential points are as yet unsupported by experimental proof.

Thus hormonal factors as evidenced by the above discussion, hypersensitivity first related by Rich and Gregory and illustrated by this experiment, and hypertension, usually a result of some degree of interference with the blood supply of one or both kidneys, all seem to play a role in the development of periarteritis. Figure 2 (in this report) exemplifies how each of the above processes may enhance the production of fibrinoid change and are manifest as different yet apparently similar arterial lesions.

In individual cases, experimental or clinical, the evidence may appear to point to one predominant agent as the most probable etiology. However, once the fibrinoid change, which may well be the common denominator in the whole process, has developed, many factors may then accentuate the vascular damage.—Ben D. McCallister, M. D., Honolulu: *J. Kansas M. Soc.,* 59:141, April, 1958.

Bedside Considerations of Heart Failure

When the physician is confronted with some abnormality, he naturally seeks one isolated cause to explain the defect. This is a fine approach except that it will rarely be rewarded with a simple answer. The word "pneumonia" once served for the explanation of an illness. It is obviously inadequate for it tells one nothing of the nature of the invading organism, the probable immune responses of the individual or the responses to be expected from antibiotics. The search goes on for a finer and finer end point of one cause, and yet the ramifications of contributing influences become broader and broader rather than narrower. The same is true of heart failue.

Congestive heart failure describes a symptom complex due to faulty heart function. The various manifestations relate to errors in function of organs of the body distant from the heart. Thus, digestive, cerebral, renal, and steroid derangements all appear.—EDITORIAL: *J. Florida M. A.,* 45:307, September, 1958.

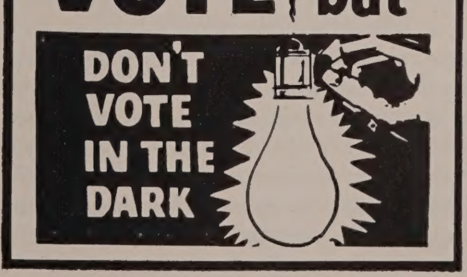
Politics Is What YOU Make It!

* * *

See you at the polls!

IF You Want a Voice In Your Government, Vote on November 4 — Get Others in Your Neighborhood To Vote.

Physicians Should Ask the Officers and Legislative Chairman of Their County Medical Society for the Facts about the Candidates.


VOTE but
DON'T VOTE IN THE DARK

Medicare Coverage Slashed . . .

Drastic Curtailment Is Effective October 1 in Keeping with Limited Congressional Appropriations; Reductions in Program Are Explained

DRASTIC curtailment of the Military Dependents Medical Care Program (Medicare) became effective October 1.

This resulted from Congressional action limiting expenditures for the Medicare Program for the current fiscal year to $72,346,000. Expenditures for Medicare have been at the rate of about $90-million. Also, Congress ordered the Defense Department to make optimum utilization of uniformed services medical facilities.

Mutual of Omaha has been designated as administrator of the medical part of the program in Ohio for this current year. Blue Cross will handle hospital administrative details.

The following explanation of how the Medicare Program will operate under the restrictions is based on an official bulletin issued by the Office of Dependents Medical Care, Washington, on August 29.

Spouses and Children Residing Apart from Sponsors

Spouses and children residing apart from sponsor will continue to be allowed selection of either uniformed services medical facilities or civilian medical sources for care authorized under the program.

When DA Form 1863 shows "Residing Apart from Sponsor—yes," in Item 4 of the claim form, the designation of this fact on the claim form by the person signing Item 14 will be sufficient, and authorized care rendered will be payable provided that the person or entity providing the care has no actual knowledge to the contrary.

Restrictions on Spouses and Children Residing with Sponsors

Spouses and children residing with sponsor will be required to utilize uniformed services medical facilities if available and adequate as determined by the commander of the medical facility. When uniformed services medical facilities are not available, a PERMIT will be furnished such dependents by the appropriate commander. This PERMIT will entitle them to receive authorized care from civilian sources at Government expense if such care is authorized under Public Law 569 and the Joint Directive, as amended. A summary of changes in the scope of authorized care is set forth below.

Action Which Must Be Taken By Physicians and Hospitals

Effective October 1, 1958, it will be necessary for physicians and hospitals rendering care to eligible dependents to take the following actions in order to insure payment of their claims for authorized care rendered:

a. When DA Form 1863 shows "Residing Apart from Sponsor—**No**," to allow payment for authorized care, a PERMIT is required as noted above **(a copy of which must be attached to the original copy of the attending physician's and the hospital's claim form), except** in the following circumstances:

(1) When spouse or child residing with sponsor is hospitalized for care authorized under the program in a bona fide acute emergency, e. g., serious injury following an accident or illness of sudden onset requiring immediate treatment at the nearest available medical facility to preserve life, or to prevent undue suffering, **a statement by the attending physician on the DA Form 1863, or attachment thereto, in lieu of a PERMIT, is required**, stating, "This case was a bona fide acute emergency."

(2) Where a spouse or child is residing with sponsor, but is away from the area of the sponsor's household on a trip, care authorized under the Program may be provided from civilian sources without a PERMIT. The statement "On Trip" in Item 3 or 4 of the DA Form 1863, by the person signing Item 14, will suffice, provided the person or entity providing the care has no actual knowledge to the contrary.

(3) A maternity case (residing with sponsor) under the care of a civilian physician on or before October 1, 1958, may be continued by that physician provided the patient has reached the second trimester of pregnancy on or before that date. In these cases a statement by the attending physician on the DA Form 1863, (or attachment thereto) will be submitted by the physician **and** the hospital to the effect that the patient was under his care on or before October 1, 1958, and that her pregnancy

had reached the second trimester on or before that date. This statement will suffice to authorize this care for payment without a PERMIT and will apply only to maternity cases where the wife resides with her sponsor. No restriction as to fredom of choice has been placed on those eligible dependents who reside apart from sponsor.

(4) Spouses and children residing with sponsor admitted to a hospital for authorized care prior to midnight, September 30, 1958, and whose hospital care resulting from this admission extends beyond September 30, 1958, will not be required to provide a PERMIT for that admission to the hospital. Nevertheless, the date of admission shown by the hospital on all claim forms submitted involving care of an eligible dependent must indicate that the admission occurred prior to October 1, 1958.

(5) Spouses and children residing with a sponsor who are receiving authorized care from a physician and who are admitted to a civilian hospital prior to midnight, September 30, 1958, will be authorized care by a civilian physician without a PERMIT, provided the physician shows the date of admission to a civilian hospital on his claim form, and this date is prior to October 1, 1958.

Here Is Way Permits Should Be Handled

PERMITS, where required, must be attached to the original copies of DA Form 1863 on claims submitted by attending physicians and hospitals. Claims submitted by other than attending physicians or hospitals, e. g., Assistant Surgeon, Radiologist, Pathologist, Anesthesiologist, Dentist (when not in capacity of the attending physician), Consultant, Physiatrist, Private Duty Nurse, Anesthetist, and Physical Therapist, will be authorized for payment without a PERMIT. However, claim form (DA Form 1863) must contain a statement by the person executing the certification in Item 14 that a PERMIT was furnished to the attending physician (identified by name) and/or to the hospital (identified by name).

Care No Longer Payable Under the Dependents' Medical Care Program

In order to comply with budgetary limitations placed on the Dependents' Medical Care Program by the Congress for Fiscal Year 1959, rigid restrictions are immediately required. Therefore, it is necessary to curtail certain care and services currently authorized by the Joint Directive under discretionary authority vested in the Secretary of Defense by Public Law 569. **Effective October 1, 1958,** and in order to implement the above, the Joint Directive has been amended so that **the following care and services, if commenced on or after that date, will not be payable by the** Government under the Dependents' Medical Care Program:

a. Treatment of fractures, dislocations, lacerations and other wounds on an outpatient basis, previously authorized.

b. The Termination Visit. This refers to payment of a referring physician who terminates his care prior to, or upon hospitalization of, the patient. This was previously authorized and was formerly payable under Code 0042 in recently negotiated Medicare Manual and Schedule of Allowances, and Code 0011 in the original Schedule of Allowances for Physicians' Fees.

c. Outpatient pre- and post-surgical tests and procedures. These were formerly authorized in an amount of $75.00 before hospitalization, and $50.00 after hospitalization.

d. Neonatal Visits. Formerly authorized on an outpatient basis not to exceed two visits during the first 60 days, except that in the case of home or office deliveries necessary infant care may be provided on an outpatient basis during a period not to exceed 10 days following the date of delivery. Payment for this service would be in accordance with Code 0022 in the current Medicare Manual and Schedule of Allowances. The in-hospital part of care of the newborn is still allowable as part of complete maternity care, and is payable under Code 0022 in the current Medicare Manual and Schedule of Allowances, and Codes 0002 and/or

Medicare Figures For Ohio For Last Fiscal Year

Here is a breakdown on Medicare figures for Ohio for the period July 1, 1957 to June 30, 1958, taken from records of the Medicare office, Washington:

Total medical claims in Ohio, 16,955; amount $1,308,755; percentage of national as to claims filed 2.83; as to amount paid, 2.90.

Total hospital claims in Ohio, 9,980; amount $1,140,670; percentage of national, as to claims filed, 2.82; as to amount paid, 2.88.

Total amount medical and hospital claims in Ohio, $2,463,570; percentage of national, 2.89.

Total medical hospital claims filed in the nation, 951,894; the total amount paid, $84,738,560.

0010 in the original Schedule of Allowances for Physicians' Fees.

e. The treatment of acute emotional disorders. This was formerly authorized, when an acute emergency existed. Except, however, care of an acute emotional disorder may be furnished to a spouse or child, if required, during the period of hospitalization of that spouse or child for a condition that **does** qualify as authorized care.

f. Elective surgery.

"Elective Surgery" has been defined below and **does not** constitute authorized care:

> "Medical or surgical care that is desired or requested by the patient which in the opinion of the cognizant medical authority can be planned, subsequently scheduled, and effectively treated at a later date without detriment to the patient, e. g., diagnostic surveys, cosmetic surgery, reconstructive surgery, tonsillectomies, uncomplicated hernias, and interval appendectomies."

Surgical Procedures Authorized For Payment

Surgical Emergencies Requiring Hospitalization. Bona fide surgical emergencies, which cannot be handled on an outpatient basis, will continue to be honored for payment under the Program. Such patients will necessarily be acutely ill and in need of **immediate** hospitalization and treatment. Examples include perforated duodenal ulcer, hemorrhage with shock, bowel obstruction, and similar recognized emergencies.

Acute Surgical Conditions. It is well recognized that many acute surgical conditions develop which, while requiring prompt treatment in a hospital, are not considered emergencies under the Program. Under such circumstances the patient is acutely ill and must receive treatment without delay as time will not permit the patient to anticipate or plan for the care required. The procedure required for the treatment will of necessity be carried out at the earliest practicable time compatible with sound surgical judgment and the proper preparation of the patient for surgery. The spirit of this requirement is that the ill patient is in clinical need of hospitalization without delay with a view to surgical correction of the basic condition. Examples are acute appendicitis, empyema of the gall bladder, twisted ovarian cyst, strangulated hernia, pelvic abscess, and renal or ureteral calculi with colic. When the charge physician so indicates that an acute requirement existed, payment will be authorized. Suspected or proven malignancy, requiring hospitalization, will be payable only if the case qualifies under this or the preceding sub-paragraph.

Injuries Requiring Hospitalization. Injuries of such clinical severity as to require hospitalization will continue to be payable. Hospitalization is authorized only for the treatment of the acute phase. Readmission for treatment of chronic stages or sequelae of injury would not be payable unless an acute medical or an acute surgical requirement is shown, such as, osteomyelitis, with acute exacerbation.

Surgical Procedures Not Authorized For Payment

Elective surgery described above which, from a practical viewpoint, permits the patient and the physician to plan for the surgery required, is not authorized for payment under the program. Hence, a great many surgical procedures payable in the past are not now authorized unless, due to unusual circumstances. Examples are Tonsillectomy, Dilation and Curettage, Hysterectomy (Routine), Ligation of Fallopian Tube, Heart Surgery, Submucus Resection, Rhinoplasty, and Reconstructive Orthopedic and Plastic Procedures.

No Change Made in Acute Medical Conditions and Dental Care

The provisions pertaining to the treatment of acute medical conditions remain unchanged. However, the admission of patients not actuely ill for diagnostic surveys will not be payable.

The provisions pertaining to dental care remain unchanged. However, adjunctive dental care is now payable only when it is an integral and necessary part of surgical or medical care now authorized. It must be clearly shown that the dental care furnished was required for the proper treatment of the basic medical or surgical condition for which the patient was hospitalized.

Treatment Commenced Before Oct. 1, 1958 Where Care Has Been Deleted

Hospitalized Patients. A patient will be deemed to have commenced receiving such care if admitted to the hospital prior to midnight on September 30, 1958. Care is authorized during that period of hospitalization if the claim form shows an admission date earlier than October 1, 1958. The care referred to here includes the termination visit and outpatient pre- and post-surgical tests and procedures associated with this admission.

The Two Neonatal Visits previously authorized will be payable, if the birth occurs prior to midnight September 30, 1958, and if the physician's claim form contains a statement to that effect.

Outpatient Injuries will be deemed to have commenced prior to midnight September 30, 1958, and, therefore, payable if the patient contacted a source of care prior to that time, and if the source of care so states on the claim form.

Group Life Plan Is Now in Effect; 1234 Are Enrolled; Additional Chance Offered on District Basis

THE Group Life Insurance Plan of the Ohio State Medical Association became effective September 1. As of September 9, 1234 members and employees of members were covered for the basic insurance of $10,000 for which they had subscribed.

Of that number 365 members subscribed for additional $10,000 coverage for which evidence of insurability had to be submitted. The additional insurance taken by the 365 members will become effective as soon as the Home Office of Union Central Life Insurance Co. has processed the applications and given approval. The total amount of basic insurance in force as of September 1 was $8,240,250.

The state-wide enrollment was terminated on September 18. In the near future, enrollment will be re-opened in one of the Councilor Districts for a period of 60 days during which those who have not enrolled will be able to enroll without evidence of insurability, providing at least 50 per cent of the members in the District enroll, counting those who enrolled during the state-wide enrollment. All Councilor Districts will be handled in this way eventually.

Board of Abdominal Surgery Not AMA - Approved

During the past several weeks many Ohio physicians have received an invitation, originating at Boston, to become an affiliate of an organization calling itself the American Board of Abdominal Surgery. In response to inquiries, the Columbus Office of the Ohio State Medical Association requested information on the organization from the American Medical Association. Following is a statement issued in Mid-August by the Council on Medical Education and Hospitals of the AMA:

"The Council on Medical Education and Hospitals has received many inquiries from individuals who have been invited to submit applications for the Founders Group of the American Board of Abdominal Surgery. The inquirers have been concerned as to whether the American Board of Abdominal Surgery is approved by the Council on Medical Education and Hospitals.

"Several years ago the Council was delegated the responsibility to act for the American Medical Association to grant approval to specialty boards which met appropriate requirements and standards. The Council on Medical Education and Hospitals continues to fulfill this function, assisted by the Advisory Board for Medical Specialties, which is composed of representatives from each of the approved specialty boards.

"The American Board of Abdominal Surgery has not sought recognition from either the Council on Medical Education and Hospitals or the Advisory Board for Medical Specialties. It is, therefore, not approved by either of these groups."

UMW Fund Expended $58,135,000 On Health Benefits Last Year

United Mine Workers' Welfare and Retirement Fund spent $138,501,681 in fiscal year that ended June 30, 1958, of which $58,135,684 went for medical, rehabilitation and hospitalization benefits. The detailed accounting is given in Fund's latest annual report. Hospital days totaled 1,458,385, with 85,426 beneficiaries. Inpatient physicians' visits totaled 1,311,088, plus 969,801 office and outpatient clinic consultations.

In the previous year, $59,584,594 was spent in this field on 1,631,144 days of hospitalization, 1,556,111 visits by physicians to hospitalized patients and 885,944 consultations in clinics and offices. There were 93,679 beneficiaries.

The report attributes dollar savings to policy of restricting payments to "physicians and hospitals whose services are determined by the Fund's Medical, Health and Hospital Service to be necessary and essential." The report says Fund's experience indicates "great majority of physicians understand fully the Trust Fund's positon and desire to cooperate with the Fund in providing good medical care and preventing waste of Fund resources."

Diseases of the Chest

The Council on Postgraduate Medical Education of the American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, will present the following Postgraduate Courses this fall: Clinical Cardiopulmonary Physiology, Edgewater Beach Hotel, Chicago, October 13-17. Diseases of the Chest, Park-Sheraton Hotel, New York City, November 10-14.

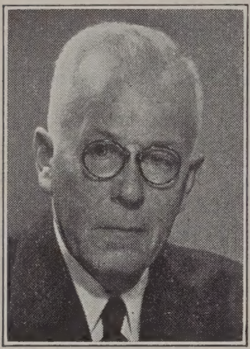
AMEF Merits Physician Support . . .

Aid from the Medical Profession Will Be Solicited in Fall Campaign To Promote Medical Education; AMEF Chairman for Each County Named

OHIO physicians again have an opportunity this Fall to support the Nation's medical schools by contributing to the American Medical Education Foundation.

Dr. Merrill D. Prugh, Dayton, is chairman of the Ohio AMEF committee, which is composed of the 11 District Councilors of the Ohio State Medical Association.

In 1951 two non-profit organizations were formed to encourage private support of the medical schools. The American Medical Education Foundation was established by the American Medical Association to raise funds from the medical profession. The National Fund for Medical Education was organized to solicit financial support from business and industry.



M. D. Prugh, M. D.

Since 1951 a total of $17,900,869 has been distributed to the medical schools by the two organizations. Of that amount, $6,741,465 came from physicians and medical organizations. In addition, physicians contribute approximately $1,500,000 per year directly to their own schools.

Allotments to the medical schools have been used for such worthy purposes as: purchase of teaching equipment; improvement of faculty salaries, particularly for younger staff members and improvement of library facilities.

If he wishes, the AMEF donor may designate his gift for his own Alma Mater or any other school in which he is particularly interested. Contributions which are not specifically earmarked by the donor are pooled and distributed among all the schools on the following basis: a uniform gift for each school plus an additional award depending on the number of students enrolled.

During 1957, a total of 44,155 contributors gave $984,884.40 to AMEF. In addition, 50,364 physicians gave a total of $3,020,600.43 directly to the Alumni Funds of their own schools, making a grand total of $4,005,484.83 contributed by physicians to the cause of medical education during the year.

Ohio Record High

Ohio's AMEF total for 1957 was a record high of $33,141.87 from 717 contributors. Included in that amount was $10,682.34 raised through various projects by the Woman's Auxiliaries throughout the state, an accomplishment for which the auxiliaries received national recognition. Ohio physicians numbering 3,646 also contributed $132,566.56 directly to the Alumni Funds of medical schools. The grand total for Ohio in 1957 was $165,708.43 from 4,363 donors.

Realizing the importance of keeping the Nation's medical schools independent and financially solvent, Dr. Prugh, the members of the 1958 AMEF state committee and the local chairmen are hopeful that many more Ohio physicians will join the ranks of their more than 4,000 colleagues who made gifts for medical education last year either through AMEF or directly to medical schools.

A local chairman has been appointed for each county medical society to follow-up the mail solicitations which will begin on or about October 1. The county chairmen are:

First District

ADAMS—Herman P. Hyder, Bentonville
BROWN—Leslie Hampton, Jr., Sardinia
BUTLER—Gilbert P. Wagoner, Middletown
CLERMONT—John M. Coleman, Loveland
CLINTON—Edmond K. Yantes, Wilmington
HAMILTON—Charles A. Sebastian, Cincinnati
HIGHLAND—Leland Dale McBride, Hillsboro
WARREN—D. Paul Ward, Pleasant Plain

Second District

CHAMPAIGN—Arthur B. Ream, Mechanicsburg
CLARK—Lillian M. Posch, Springfield
DARKE—Gilbert E. Sayle, Greenville
GREENE—Harvey B. McClellan, Xenia
MIAMI—William T. Wilkins, Jr., Piqua
MONTGOMERY—Kenneth D. Arn, Dayton
PREBLE—A. L. Ross, West Alexandria
SHELBY—John H. Kerrigan, Sidney

Third District

ALLEN—F. Miles Flickinger, Lima
AUGLAIZE—Elizabeth Y. Kuffner, St. Marys
CRAWFORD—William C. Manthey, Galion
HANCOCK—Harry J. Miller, McComb
HARDIN—Robert H. Zeis, Kenton
LOGAN—Charles H. Thompson, West Mansfield
MARION—Frederick G. Smith, Marion
MERCER—Edgar J. Willke, Maria Stein
SENECA—Avery D. Powell, Tiffin
VAN WERT—S. A. Edwards, Van Wert
WYANDOT—F. M. Smith, Sycamore

Fourth District

DEFIANCE—James E. Cameron, Defiance
FULTON—Clarence F. Murbach, Archbold
HENRY—Richard L. Gilson, Napoleon
LUCAS—Sam H. Patterson, Toledo
OTTAWA—Cyrus R. Wood, Port Clinton
PAULDING—John H. Schaefer, Paulding
PUTNAM—David A. Barr, Lima
SANDUSKY—M. M. Riddell, Fremont
WILLIAMS—Russell K. Ameter, Bryan
WOOD—Halford E. Whitacre, Bowling Green

Fifth District

ASHTABULA—Alfred A. DeCato, Ashtabula
CUYAHOGA—Donald B. Cameron, Cleveland
GEAUGA—Alton W. Behm, Chardon
LAKE—Morris G. Carmody, Painesville

Sixth District

COLUMBIANA—A. J. Knapp, East Liverpool
MAHONING—Harry A. Smith, Youngstown
PORTAGE—John S. Deyell, Ravenna
STARK—Blanchard V. Antes, Canton
SUMMIT—James C. Oberholtz, Akron
TRUMBULL—Densmore Thomas, Warren

Seventh District

BELMONT—Fred Wm. Cook, Jr., Martins Ferry
CARROLL—Joseph D. Stires, Malvern
COSHOCTON—Gerald A. Foster, Coshocton
HARRISON—Dwight C. Pettay, Cadiz
JEFFERSON—M. H. Rosenblum, Steubenville
MONROE—Byron Gillespie, Woodsfield
TUSCARAWAS—Samuel H. Winston, Dover

Eighth District

ATHENS—Robert E. Main, Athens
FAIRFIELD—Kenneth A. Gaines, Lancaster
GUERNSEY—F. Gordon Lawyer, Cambridge
LICKING—Warren N. Koontz, Newark
MORGAN—Henry Bachman, Malta
MUSKINGUM—Walter K. Chess, New Concord
NOBLE—E. G. Ditch, Caldwell
PERRY—Ralph E. Herenden, Jr., New Lexington
WASHINGTON—W. D. Turner, Marietta

Ninth District

GALLIA—Marcus J. Magnussen, Gallipolis
HOCKING—George B. Watson, Adelphi
JACKSON—Garrett B. Ackerman, Wellston
LAWRENCE—George Newton Spears, Ironton
MEIGS—Charles J. Mullen, Pomeroy
PIKE—Mack E. Moore, Piketon
SCIOTO—William J. Hartlage, Sciotoville
VINTON—H. D. Chamberlain, McArthur

Tenth District

DELAWARE—James G. Parker, Delaware
FAYETTE—Frank C. King, Washington C. H.
FRANKLIN—L. Chandler Roettig, Columbus
KNOX—Henry T. Lapp, Mt. Vernon
MADISON—Paul G. H. Wolber, London
MORROW—Andrew Maciurak, Cardington
PICKAWAY—Walter F. Heine, Circleville
ROSS—F. W. Nusbaum, Chillicothe
UNION—James W. Sampsel, Marysville

Eleventh District

ASHLAND—John M. Strait, Ashland
ERIE—Henry W. Lehrer, Sandusky
HOLMES—Neven P. Stauffer, Millersburg
HURON—George F. Linn, Norwalk
LORAIN—Lewis B. Stephan, Lorain
MEDINA—R. F. Fasoli, Brunswick
RICHLAND—Melvin Christian, Mansfield
WAYNE—Robert E. Schulz, Wooster

Do You Know? . . .

George H. Saville, Director of Public Relations, Ohio State Medical Association, has been named chairman of the Advisory Committee to the Department of Public Relations of the American Medical Association. The committee, appointed by the Board of Trustees of the A. M. A., consists of nine medical society executives from throughout the country.

* * *

Dr. Ross M. Knoble, Sandusky, has been named chief surgeon of the Ohio Soldiers' and Sailors' Home in Sandusky. He succeeds the late Dr. Fernand J. Leblicq in that post.

* * *

Dr. Carl J. Wiggers, Cleveland, professor emeritus of physiology at Western Reserve, recently was conferred the honorary doctor of science degree by Ohio State University.

Outstanding Faculty Announced For Sixth District PG Day

Physicians of the Sixth Councilor District have received direct mail information about the Postgraduate Day scheduled at the Sheraton-Mayflower Hotel, Akron, on Wednesday, October 22. Physicians outside of the district are invited to write for topics and other details to: The Summit County Medical Society, Second National Building, Akron. Advance Registration is $10.

Registration opens at 8:00 a. m. with the program starting at 9:30. The program has been approved by the American Academy of General Practice for eight hours credit.

The faculty has been announced as follows:

Surgery — Dr. George Block, University of Michigan; Dr. Richard B. Cattell, Lahey Clinic; Dr. Deryl Hart, Duke University; Dr. Paul Hodgson, University of Michigan; Dr. William Regan, University of Michigan.

Medicine—Dr. J. Earle Estes, Mayo Clinic; Dr. William Jefferies, Western Reserve University; Dr. R. G. Siekert, Mayo Clinc; Dr. Joseph Vanderveer, University of Pennsylvania.

Pediatrics—Dr. John Caffey, Columbia Presbyterian Medical Center; Dr. Edward A. Mortimer, Jr., Western Reserve University; Dr. G. Mason Sones, Cleveland Clinic; Dr. Mitchell Rubin, University of Buffalo.

Obstetrics & Gynecology—Dr. M. Edward Davis, University of Chicago; Dr. Allan F. Guttmacher, Mt. Sinai Hospital, New York; Dr. John G. Masterson, State University of New York; Dr. Clyde L. Randall, University of Buffalo; Dr. Frederick Zuspan, Western Reserve University.

Hospital Needs of Aged . . .

Policy on Ways to Meet This Question Is Adopted by American Hospital Association at Recent Annual Session in Chicago; Steps Are Outlined

THE House of Delegates of the American Hospital Association, meeting in Chicago in August, adopted a statement of policy with respect to meeting the hospital needs of the aged. The statement, which supersedes all previous actions taken by the association, follows:

1. The American Hospital Association is convinced that retired aged persons face a pressing problem in financing their hospital care.

2. It believes that federal legislation will be necessary to solve the problem satisfactorily. It has, however, serious misgivings with respect to the use of compulsory health insurance for financing hospital care even for the retired aged.

3. It believes that all possible solutions must be vigorously explored, including methods by which the dangers inherent in the Social Security approach can be avoided.

4. It believes that every effort should be made to meet the hospital needs of the retired aged principally through mechanisms utilizing existing systems of voluntary prepayment. However, it is conceivable that the use of Social Security to provide the mechanisms to assist in the solution of the problem of financing these needs may be necessary ultimately.

5. It believes that any legislation developed to provide for government participation to meet the hospital needs of the retired aged should be so devised as to strengthen the voluntary prepayment systems, and should conform to the following principles:

   a. Legislation designed to provide for the hospital needs of the retired aged should provide essential hospital services and should exclude custodial care provided for nonmedical reasons.

   b. Government participation should be restricted to persons over 65 who are not regularly and substantially employed. The voluntary prepayment system provides a satisfactory mechanism for the coverage of other persons, regardless of age.

   c. Any program in which the federal government participates to meet the hospital needs of the nonindigent aged should emphasize individual responsibility and make the application of a means test unnecessary for obtaining benefits.

   d. Such a program should be based on the service benefit principle and should provide benefits sufficiently comprehensive to remove the major economic barriers to hospital care for the retired aged.

   e. Such a program should make benefits available through nonprofit prepayment plans.

   f. Hospitals should be paid fully for the cost of care rendered.

   g. Such a program should not provide services in facilities operated by the federal government.

   h. Such a program should provide reasonable criteria to determine the eligibility of hospitals to participate, but the federal government should be precluded from interfering in the administration and operation of hospitals providing the services.

   i. Such a program should maintain the free choice of doctor and hospital by the recipient.

   j. Such a program should permit and encourage continuous adaptation to new knowledge in the provision of services.

Another Movie In Medico-Legal Series Now Available

The third film in the series being sponsored by the Wm. S. Merrell Company, and prepared jointly by the American Medical Association and the American Bar Association, had its premier showing at the Palace Hotel in San Francisco on June 25 during the AMA meeting. It is entitled "The Man Who Didn't Walk" and it concerns itself with the condition known as traumatic neurosis. It is of particular interest to both physicians and lawyers because traumatic neurosis, though not universally accepted as a clinical entity, is, nevertheless, frequently used today by claims-seeking plaintiffs as an explanation of the plaintiff's disability.

The film points up the fact that it is the responsibility of both physician and attorney to conduct complete examinations, to collaborate in pre-trial conferences, and to present testimony to help the jury decide this often baffling and puzzling problem of law and medicine.

If you want this film to be shown at one of your county society meetings, have your program chairman contact the AMA film library, 535 North Dearborn Street, Chicago 10, Illinois.

Review of What Congress Did . . .

Unusual Number of Bills Affecting Medicine or Health Taken Up by 85th Congress; Prospects on Major Issues for the Next Session Are Outlined

FOLLOWING is a review of the first and second sessions of the 85th United States Congress which adjourned recently, prepared by the Washington Office of the American Medical Association.

The second session of the 85th Congress, beset with space age and other problems and operating in the charged atmosphere of an election year, found time to take up an unusual number of bills of interest to medicine. It passed more than a dozen. Just as notable were two bills that did not pass.

While the Forand bill for a hospitalization program under social security failed to clear the House Ways and Means Committee, the committee did order the Department of Health, Education, and Welfare to make a thorough study of the problem of financing medical care of the aged, with emphasis on use of social security. Because the report is due by next February 1, the basic issue is almost certain to come to the front again early in the new Congress.

Another major issue left hanging was that of tax-deferment on annuities for the self-employed—the Keogh bill. It went through the House by an overwhelming vote and won the support of 32 Senators, two factors that suggest it may be enacted next year. Following are reviews of the provisions of all major health bills enacted in both sessions of the 85th Congress, and comments on prospects for the more important measures that were left by the wayside.

Medicare Appropriations

Congress took a long look at the medicare program, now nearing its second anniversary, and decided that the civilian phase of the program had to be curtailed in favor of greater use of military facilities. **(See Pages 1326-1328 for detailed Medicare story.)**

Social Security Amendments

As it has done every election year since 1950, Congress again amended the Social Security Act. It increased Old Age, Survivors and Disability Insurance benefits by 7 per cent, in response to demands that benefits keep pace with the cost of living. It provided an additional $197 million for public assistance recipients, and gave states greater flexibility in use of federal funds for financing the medical care of the aged, blind, the disabled and dependent children. To finance the liberalizations, the law increases the taxable base from $4200 to $4800 of gross employment earnings and raises the tax in 1959 from 2¼ per cent to 2½ per cent for the employer and employee, and from 3⅜ per cent to 3¾ per cent for the self-employed. Additional increases are scheduled for 1960, 1963, 1966 and 1969. By 1969, the self-employed will be paying 6¾ per cent of earnings.

Congress left the door ajar for consideration by the next Congress of bills using the social security system to provide hospital and medical care for OASDI beneficiaries. An articulate minority wanted this enacted this year via the proposal of Rep. Aime Forand (D., R. I.), but Congress decided against it. However, the House Ways and Means Committee directed the administration to make a study and report by next February on the various possibilities for financing medical care for the aged, with particular emphasis on the possible practicability of increasing OASDI taxes and using the money to purchase health insurance on retirement. **The AMA took a strong stand against using the social security system to provide such care, viewing it as a beginning of national compulsory health insurance.**

White House Conference on Aging

The President is instructed to call a White House Conference on Aging in January, 1961, by a measure passed late in the session. This national meeting will bring together federal, state and local leaders working in the field of aging. A series of state-organized meetings would precede the 1961 conference. To help the states finance these meetings, the law provides up to $15,000 a state with a minimum of $5,000. The AMA gave this legislation its full support.

Chemical Additives in Food

In an 11th hour action, the Senate passed a House-approved bill on the last day of the session which prohibits use of chemical additives in foods until their pre-testing has been approved by the Food and Drug Administration.

Health Appropriations

In response to appeals from a number of sources, the 85th Congress set a new high in money voted for the Department of Health, Education, and Welfare, particularly for the U. S. Public Health Service. The latter now is spending at the rate of close to three quarters of a billion dollars a year. Last year PHS received from Congress approximately $562 million; this year's total is $745,747,000. Research money for the seven institutes was increased nearly 40 per cent over last year, while the Hill-Burton hospital construction program received a boost of close to 55 per cent. If one is to judge from a recent study group of HEW, the peak of spending in the health field hasn't yet been reached. Congress also voted $6.9 million for the long-sought new quarters for the National Library of Medicine.

Hill-Burton Amendments

Because a full year's notice is deemed necessary in future planning, Congress voted a 5-year extension of the Hill-Burton hospital construction program. The act otherwise would expire next June. In a separate action, Congress amended the act to permit for the first time Hill-Burton loans at the same rate of interest the government pays for its own borrowing. Under the loan act, an applicant would have to comply with all H-B regulations, the same as regular H-B applicants.

Defense Reorganization

At the prodding of the House Armed Services Committee, the Defense Department is finally reorganizing. The number of Assistant Secretaries of Defense, which Congress felt had grown too large, was trimmed back by one. Defense Secretary Neil McElroy has informed Dr. Frank S. Berry, Assistant Secretary of Defense for Health and Medical Affairs, that the latter's post will not be abolished under the forthcoming reorganization of the Defense Department, which had been feared. The decision has the concurrence of the President. The American Medical Association had worked to save the post.

Public Health School Grants

Eleven schools of public health were promised a total of $1 million annually in federal grants to assist them in professional training, specialized consultative services and technical assistance with the states. The final act was simply an authorization, which means that funds will not be available until the next Congress acts.

Civil Defense Grants

To bolster sagging state civil defense programs, Congress voted grants to the states for purchase of radiological instruments, personal equipment for state and local civil defense workers and for administrative and personnel expenses. Amounts for the first category would not exceed $35 million; for the second category, not more than $2 million, and for the third, not over $25 million.

Military and VA Pay Schedules

General pay raises for the military included the same increases for physicians in the services. The law also retained the incentive pay schedule for doctors in uniform which has been in effect since 1947. Congress, in a separate act, also approved salary increases for physicians in the Veterans Administration.

Health and Welfare Plans

To correct abuses in health and welfare plans, Congress after considerable debate voted a measure requiring both labor and management health and welfare plans to make annual financial reports to the Secretary of Labor. It exempts plans with fewer than 25 members. Fines as high as $10,000 or five years imprisonment are provided for falsification of reports.

Research Facilities Extension

Two years ago Congress voted a new program of grants to help medical schools and similar facilities doing research in various crippling and killing diseases to construct laboratories and similar buildings or to remodel existing structures. The program was to run for three years, with an annual appropriation of $30 million. With a backlog of applications, the administration sought an extension for another three years. It also asked for a clarification of "multi-purpose" facilities. In the process, the bill was amended in committee so that money would have been available for both research and teaching facilities. This back-door approach to medical school aid later was dropped by the committee, because it was felt that it would jeopardize passage of the simple extension.

Doctor Draft Extension

Under this act passed in the first session, selective service has authority until July 1, 1959, to call certain physicians up to age 35 for military service. Only those doctors with obligations under the regular draft and who have been deferred for any reason may be called. Although the military has been getting enough doctors through new graduates and volunteers, it expects to ask for another extension next year.

Jenkins-Keogh Tax Deferral

The drive to give the self-employed equal treatment with the employed in setting aside tax-deferred sums for retirement plans moved closer

Some Excellent Postgraduate Programs in Various Sections Of the State Are in Prospect for Ohio Physicians

In the September issue of *The Journal* a list of postgraduate courses in various areas of Ohio was published, beginning on page 1190. Some of these programs were scheduled in September and early October. Others are scheduled in the near future and offer excellent opportunities for physicians in those areas. Here is a list of postgraduate courses announced to *The Journal* for the near future:

October 17—Mississippi Valley Trudeau Society Annual Meeting, Dayton (see page 1191, September issue).

October 19—Third Annual Session on Rheumatic Diseases, Ohio State University, Columbus (see page 1193, September issue).

October 22—Sixth District Postgraduate Day, Akron (see page 1331, this issue).

November 1—Columbus Academy of Medicine, Clinic Day, Columbus (see pages 1341-1342, this issue).

November 5—Central Ohio Heart Association, Program on the Radiologist's Role in Cardiology, Columbus, page 1352, this issue.

Series of Postgraduate Courses—Bunts Educational Institute, Cleveland (see page 1193, September issue).

than ever to enactment. A bill passed the House late in July with only a smattering of opposition. But it died in the Senate Finance Committee; a major factor was Treasury Department insistence it would result in a large tax revenue loss. AMA, in concert with the American Thrift Assembly, pressed hard for enactment. New efforts to get the measure passed in the 86th Congress are being planned.

Community Facilities Loans

A bill that started out as an anti-recession measure lost steam as it progressed in Congress. It provided for low-interest loans to states and communities for a wide range of public works, including construction of community hospitals. The measure was voted down in the House after it had passed the Senate.

Medical School Construction Aid

Bills to authorize one-time grants for new and existing medical schools to build class-rooms were pending in both House and Senate at adjournment. No bill was reported to the floor because of (1) concern over the segregation issue, (2) a question of whether the states have exhausted all resources, and (3) a reluctance of some committee members to spend the money now.

Civil Aviation Medicine

Efforts to establish a Civil Air Surgeon with broad authority in civilian air safety failed to pass. But with creation of the Federal Aviation Agency, administration assurances have been given that the needs of aviation medicine will be considered in setting up the new agency. The AMA was a strong supporter of the idea of a Civil Air Surgeon.

Veterans Hospitalization

Late in the session as a windup to lengthy hearings on veterans entitlement to VA hospitalization, the House Veterans Affairs Committee reported out an omnibus hospitalization bill. The measure had as its major objective the opening of some 5,000 additional beds which the committee maintains the Budget Bureau is holding back on. It was reported too late for final action. The AMA testified in favor of a clear spelling out by Congress of veterans entitlement to federal care.

Nursing Home Mortgage Guarantees

Efforts to provide new capital for proprietary and non-proprietary nursing homes through FHA-type mortgage loan guarantees failed of passage. The provision was part of an omnibus housing bill that failed to pass the House after Senate approval. Last-minute efforts to separate the nursing home portion from the bill and have it enacted also failed.

Cancer Symposium

A symposium on carcinoma of the colon and rectum will be presented at the annual scientific session of the American Cancer Society to be held October 20-21 at the Biltmore Hotel, New York City. Physicians on the program include Dr. Rupert B. Turnbull, of Cleveland.

Licensed To Practice in Ohio . . .

Certificates To Practice Medicine and Surgery in This State Are Issued To 348 Graduates of Approved Schools of Medicine Following Examinations

AS A RESULT of examinations given by the State Medical Board in June, certificates to practice medicine and surgery in Ohio were issued to 348 graduates of Schools of Medicine, Dr. H. M. Platter, secretary of the Board, reported.

Also 42 graduates of osteopathic schools were issued certificates to practice osteopathic medicine and surgery.

In the limited practice branches, certificates were issued to the following number of persons: Chiropody, 16; mechanotherapy, 3; chiropractic, 3; massage, 14; and cosmetic therapy, 4.

In the medical examinations two persons tied for highest grade attained and two tied for second place. Following are the high grades awarded: Eugene M. Ross, Cleveland, graduate of Ohio State University College of Medicine, 90.7 per cent; Yvonne M. Mohlman, Mariemont, University of Cincinnati, 90.7 per cent; Myron Moshowitz, Cincinnati, University of Cincinnati, 90.3 per cent; Gordon E. Hanusek, Hamilton, Ohio State University, 90.3 per cent; Luther J. Barth, New Washington, Ohio State University, 90.2 per cent.

Other actions of the Board at its August 14 meeting included that in regard to Dr. Joseph A. Geer. The Board modified the indefinite suspension of Dr. Geer to permit him to obtain employment in state institutions. He is not to engage in private practice and must not violate his parole.

Following is the list of those licensed to practice medicine and surgery, with city of residence and medical school of graduation:

Ohio State University — Herman I. Abromowitz, Dayton; Joseph M. Albrecht, Dayton; Robert F. Amicon, Columbus;

Bernard Barron, Cleveland; Luther J. Barth, New Washington; Merle M. Berman, Columbus; Charles D. Boyle, Warren; Richard E. Brashear, Upper Arlington; Dudley F. Briggs, Frankfort; Jerome H. Brodish, Columbus; Richard W. Brush, Struthers; Jerome Burman, Youngstown; Dolores J. Burton, Dayton; Robert P. Bushell, Columbus; Paul R. Bybee, Cincinnati;

Frederick L. Clegg, Bellefontaine; Eugene J. Colangelo, Columbus; John F. Coleman, Toledo; Frank W. Crowe, Ironton; Jerry D. Culberson, Grove City;

Galen H. Davis, Pennsville; Robert K. Dellinger, Cleveland; James V. Dindot, Grover Hill; Paul A. Ebert, Columbus; Charles R. Everett, North Canton;

Edward Lynn Farnham, Alliance; Robert D. A. Fisher, Cleveland; Harvey M. Friedman, Berea; Robert C. Frymier, Akron; Thomas P. Fuller, Cleveland;

John V. Gaeuman, Oberlin; Darrel D. Gant, Caldwell; Jack M. George, Columbus; Kenneth L. Gerson, Cleveland Heights; John B. Gibbs, Athens; Ian G. Gill, Cleveland; Richard M. Goodman, Chillicothe; Harold E. Grover, Oak Harbor; Alan Josef Gutman, Cleveland;

Gordon E. Hanusek, Hamilton; Richard E. Hartle, Kenton; Walter H. Hauser, Columbus; Thelma E. L. Herwig, Toledo; Theodor F. Herwig, Columbus; Donald E. Hoffman, Marion; Robert L. Holladay, Hillsboro; Asher O. Hoodin, North Bend; Stewart B. Hoover, Welshfield; Thomas K. Huggins, Bucyrus; H. Robert Hume, London;

William H. James, Warren; Edward A. Johnson, Gahanna; Kenn H. Johnson, Hiram; Eugene S. Jurczyk, Lorain;

Merlin W. Kampfer, Maumee; Richard A. Katz, Canton; Daniel P. Kenny, Brewster; Jack D. Kerth, Dayton; Paul T. Kinkade, Zanesville; Marion E. Kintner, Alvordton; Alan H. Klein, Springfield; Richard M. Klein, New Philadelphia; Donald R. Kmetz, Rocky River; Ernest Kopstein, Cleveland Heights; Edward A. Kuehn, Toledo; Herbert P. Lash, Cleveland;

Kenneth L. Learey, Columbus; Victor G. Lenzo, Newcomerstown; William L. Licklider, Columbus; John R. Linscott, The Plains;

Jay S. Malkoff, Youngstown; George J. Mallo, Akron; Thomas R. Marshall, Cleveland; Kayoshi Masuoka, Akron; Clarence L. Maxwell, Hilliards; Robert H. McCoy, Circleville; John F. McHugh, Shelby; Duane D. Mehlman, Port Clinton; Ernest S. Melaragno, Columbus; Henry C. Mellette, Johnstown; Morton D. Merchey, Youngstown; Donald E. Mills, Mansfield; Paul W. Montgomery, Columbus;

Donald H. Naftulin, Fremont; Darell E. Nicodemus, Columbus; Edward J. Noble, Jr., Grove City; John D. Nofzinger, Toledo; Joseph F. Oser, Jr., Barberton; Michael O. Phillips, Marion; Thomas A. Picard, Conneaut; Herbert L. Queen, Struthers;

Walter W. Randolph, Jr., Toledo; Lloyd F. Redick, Jenera; William B. Reinbold, Cuyahoga

Have You Voted in the OSMA Poll on Whether or Not Physicians Should Be Included Under Federal Social Security?

Each member of the Ohio State Medical Association has been mailed a folder and ballot on the subject "Should Physicians Be Included in the Federal Social Security Program?" The ballot is to be marked "yes" or "no" and returned to the Columbus Headquarters office, 79 E. State Street where the returns will be tabulated by a special committee.

The poll is being made on order of The House of Delegates at its last meeting in Cincinnati. The results are to be transmitted by OSMA delegates to the House of Delegates of the American Medical Association at the December meeting.

Deadline for returning the ballot is October 31.

Members who wish to refresh their memories on arguments for and against Social Security for physicians are invited to read the series of articles that have appeared in *The Journal* at the direction of the House of Delegates. These arguments appeared in the following issues on pages indicated: July issue, pages 868-884; August issue, pages 1010-1020; September issue, pages 1138-1150.

Falls; Roger L. Rian, Mt. Vernon; Eugene M. Ross, Cleveland;

Bruce J. Sand, Columbus; James B. Sauers, Greenwich; Victor M. Schultz, Canton; Allan J. Schutt, Defiance; Ann Holtzmuller Schutt, Defiance; Donald W. Shanabrook, Akron; Richard P. Sharp, Dayton; William V. Sharp, Cuyahoga Falls; Harry J. Shaver, Columbus; Edward L. Sherrer, Jr., Rocky River; John P. Shultz, Urbana;

Frank S. Sikora, Lorain; Henry R. Silverman, Jr., Dayton; Frank Fuller Snyder, Salem; Robert P. Stanton, Hamden; William A. Stewart, Bowling Green; Alfred E. Stockum, Canton; Frank W. Stroebel, Cleveland; Richard B. Stuart, Pataskala; Karoly Szentendrey, Cleveland;

Richard F. Taylor, Columbus; John W. Terlesky, Cleveland; Donald M. Thaler, Painesville; Russell L. Thomas, Cuyahoga Falls; Richard P. Thorn, Akron; John Vasko, Cleveland; Edward H. Vogel, Bellevue;

Leo T. Wagenbrenner, Columbus; Don W. Wehling, Barberton; Lawrence S. Weisman, Columbus; Donald E. Weiss, Cleveland; Larry L. Weiss, Akron; Richard L. Whitmer, Vandalia; Thomas E. Wilson, Columbus; Murray G. Winchell, Fairport Harbor; James McG. Wright, Columbus; Thomas E. Wright, Worthington;

Barry Yulish, Cleveland; Mark H. Zangmeister, Lithopolis; Charles E. Zepp, Columbus.

University of Cincinnati—William R. Adkins, Huntington, W. Va.; William M. Adler, Cincinnati; Taki Anagnoston, Dayton; Robert B. Arnold, Lebanon; Arthur K. Asbury, Cincinnati;

George Benzing, III, Hamilton; Carter R. Bishop, Cincinnati; Daniel T. Bolovan, Warren; Gerald E. Boyd, Lima; Thomas E. Broderick, Cincinnati; Cecil R. Burkhart, Fairborn; Patrick A. Clement, Euclid; John C. Damron, Mansfield;

George T. Donovan, Fort Wright, Ky.; William D. Dooley, Middletown; Albert Dreskin, Irvington, N. J.; William V. Dugan, Barberton; Harold H. Earnhart, Waynesville; Thomas E. Egan, Ft. Mitchell, Ky.;

Sheldon Farber, Cincinnati; Robert G. Feldman, Cincinnati; Edward E. Fisher, Cleveland; Richard K. Goodrich, Zanesville; Gary J. Greenlee, Manchester; John D. Gundzik, Cleveland;

Fouad A. Halaby, Cincinnati; Daniel Hartston, New York City; Joyce N. Herrold, Lancaster; William B. Hofmann, Trotwood; Donald J. Holzberg, Cincinnati; Marion R. Huston, Millersburg; Donald B. Jaffe, Cincinnati; George P. Janetos, Hamilton; Richard J. Jarvis, Canton; Jerry W. Jones, Covington, Ky.;

George J. Kabat, Jr., Cincinnati; Richard I. Kent, Cincinnati; Elmore A. Kindel, Jr., Cincinnati; Philip D. Kinnard, Bellefontaine; Edward J. Kremchek, Cleveland;

Jack L. Maffett, Carrollton; Donald J. McSurdy, Harrisburg, Pa.; William S. Michael, Jackson; Rudy G. Moc, Vermilion; Yvonne M. Mohlman, Mariemont; Myron Moshowitz, Cincinnati;

Charles H. Neilson, Sunbury; Edward D. Nusbaum, Richmond, Ind.; Thomas C. Payne, Dayton; Homer D. Petrou, Shelbyville, Ky.; Robert J. B. Price, Tipp City; Casimer F. Radkowski, Cleveland; Robert E. Rakel, Cincinnati; Herschel M. Richter, Cincinnati; Robert E. Robbins, Lexington, Ky.; Gerald A. Rosenberger, Defiance;

Martin Saidleman, Lebanon; Donald J. Schwieterman, New Bremen; William E. Scully, Cincinnati; Otto F. Sieber, Jr., Cincinnati; Donald P.

Smith, Sycamore; Duane H. Smith, Lyons; Calvin R. Stewart, Hubbard; James I. Tennenbaum, Cincinnati;

Thomas U. Todd, Cincinnati; Ramon D. Turman, Lorain; Harold D. Udelman, Cincinnati; Rudolph W. Vollman, Southgate, Ky.; William B. Walters, Archbold; Roger F. West, Cincinnati; John Allen Whitesel, III, Oxford; Samuel M. Wigser, Cincinnati; Robert A. Wolf, Cincinnati; Karl E. Yaple, Cincinnati.

Western Reserve University—Donald Anthony, Jr., Conneaut; Franklin J. Arnold, Jr., Hartville; Lester Baker, Jr., Decatur, Ill.; John H. Bauman, Bluffton; Richard L. Baumgartner, E. Cleveland; Abraham B. Bergman, Cleveland Heights;

James Borden, Cleveland; William D. Bradford, Rochester, N. Y.; William R. Brinker, Westlake; Kenneth A. Brown, Warren; John M. Bucher, Jefferson, Pa.; Charles W. Burmeister, Johnstown, Pa.; Herman Buschke, Cleveland; Edward S. Bush, Cleveland; William T. Butler, Webster Groves, Mo.; Janet P. Butte, Steubenville;

Patricia Caughey, Detroit, Mich.; Donald E. Christensen, Cleveland; E. Christine Costley, Liberal, Mo.; Charles F. Crone, Massillon; Ted E. Cull, Ft. Recovery; Robert L. Dillenkoffer, New Orleans, La.; Edward D. Eckman, Jr., Jamestown, N. Y.; William M. Emery, Ashland;

Norbert Felber, University Hts.; Ronald B. Fleming, Berea; Richard B. Fratianne, Cleveland; Parrish W. Garver, Cleveland; Perry Anderson Henderson, Cleveland; David A. Hunt, Dayton; David E. Jenkins, Jr., Niles; John A. Jennings, Xenia; Edward W. Jensen, Cleveland;

Sheldon Kaffen, Cleveland Heights; Charles M. Klein, Rocky River; Mathilde S. Kline, Canton; Addie L. Klotz, Lakewood; Theodor Kolobow, Columbus; John M. Kuldau, Sandusky;

Irwin H. Lepow, Cleveland Hts.; Phillip I. Lerner, Cleveland; Wm. P. Mahoney, Jr., Cleveland; Richard B. Markey, Shaker Heights; Edward L. Mitchell, Cleveland; Richard E. Myers, Shaker Heights; John L. Nieman; Cleveland Heights;

Sonya S. Oppenheimer, Cleveland; James L. Phillips, West Middlesex, Pa.; Richard L. Porus, Cleveland; Stephen A. Pye, Jr., Cuyahoga Falls; Martin S. Roginsky, Cleveland; Arthur L. Rosenbaum, Lorain; Eugene Ross, Cleveland Hts.;

Howard B. Sauder, Wheeling, W. Va.; Mario P. Scibetta, Cleveland; Sadja Silberger, New Milford, Conn.; Richard E. Simmons, Akron; Raymond B. Strauss, Cleveland; Robert H. Stults, Miami, Fla.; Howard S. Sudak, Cleveland; Richard A. Thompson, Cleveland; Philip Thorngate, Monterey, Calif.; Frank C. Tiberio, Youngstown;

Donald E. Walker, Canonsburg, Pa.; Daniel T. Weidenthal, Shaker Heights; Herbert D. Weintraub, Cleveland Hts.; Sanford R. Weiss, South Euclid; August H. Wells, Elma, N. Y.; William B. Wentz, Cleveland; Charles R. Wolf, Xenia.

Graduates of Medical Schools of Other States and Canada (alphabetical by medical school of graduation)—Alfred W. Jackson, Jr., Hartville, Cornell Univ.; Donald F. Armento, Euclid, Georgetown Univ.; Thomas J. Fauble, Swanton, Georgetown Univ.; Walter E. Badenhausen, Jr., New York City, Hahnemann Univ.; William E. Masters, Warren, Hahnemann Univ.;

Jerome A. Wensinger, Marion, Loyola Univ.; Thomas R. Mainzer, Huntingdon, Pa., Jefferson Med. Col.; Lowell D. Mann, Clayton, Jefferson Med. Col.; Robert L. Michael, Jackson, Jefferson Med. Col.; Grafton F. Sieber, Cleveland, Jefferson Med. Col.; Lucius F. Sinks, Columbus, Jefferson Med. Col.; E. Milton Witthoff, Jr., Chicago, Ill., Jefferson Med. Col.;

Edward Morris, Mentor, Northwestern Univ.; Fred H. Tilock, Lorain, Temple Univ.; Joyce E. Howell, Cincinnati, Woman's Med. Col.; Marilyn F. Mahaffey, Fredericktown, Woman's Med. Col.;

Charles M. Alexander, Toledo, Univ. of Chicago; Paul M. Plueddeman, Cincinnati, Univ. of Illinois; William M. Sermonte, Cincinnati, Univ. of Illinois; Walter Bjarnesen, Levonia, Mich., Univ. of Michigan; Richard A. Morin, Alpena, Mich., Univ. of Michigan; William H. Richmond, Toledo, Univ. of Michigan; James H. Stage, Ironwood, Mich., Univ. of Michigan;

Richard W. Emmons, Rockville, Md., Univ. of Pennsylvania; John A. Murray, Carrollton, Univ. of Pittsburgh; Rodney J. Valentine, Los Angeles, Calif., Univ. of S. California;

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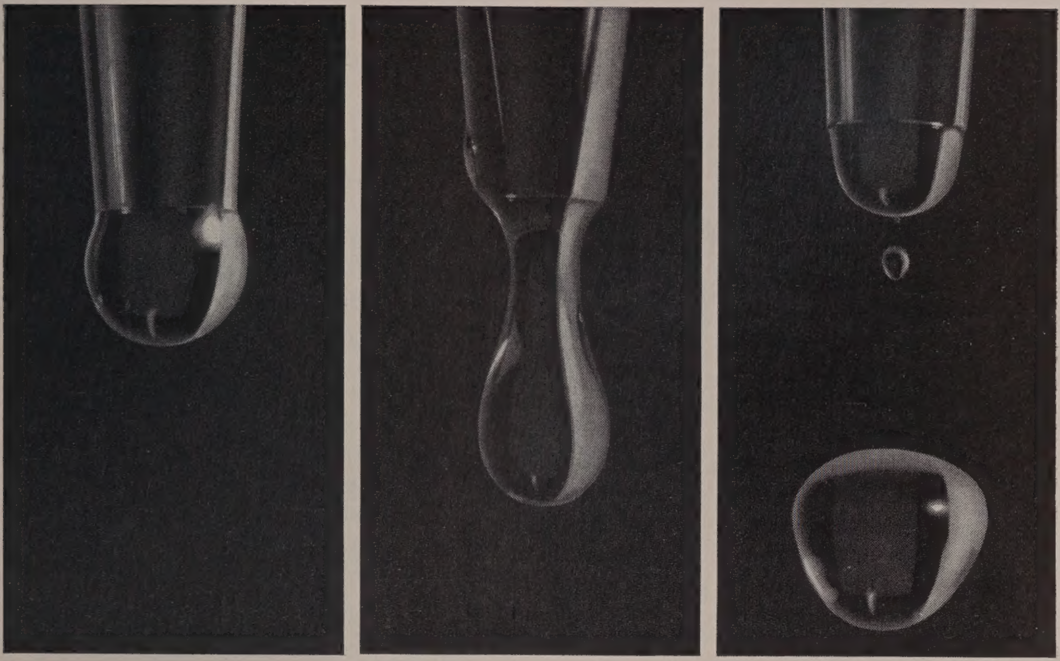
Graduates of Foreign Medical Schools (alphabetical by country in which school of graduation is located)—Irving Marcus, Richmond, Va., Univ. Adelaide, Australia; Alois W. Toegel, Hammonton, N. J., Univ. of Graz, Austria; Joseph C. Ungvari, Kirkwood, Mo., Univ. of Graz, Austria; Jacob Finkelstein, Brooklyn, N. Y., Catholic Univ. of Louvain, Belgium; Felix C. Lewkowicz, New York City, Univ. of Paris, France;

Carrie Siedentop, Park Forrest, Ill., Univ. of Berlin, Germany; Vytautas P. Digrys, Hammonton, N. J., Univ. of Erlangen, Germany; Haralds E. Birznieks, Dayton, Univ. of Frankfurt-Main,

(Continued on Page 1340)



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Germany; Annelies R. Dziadzka, Cleveland, Univ. of Hamburg, Germany; Dietrich W. Felber, Akron, Univ. of Hamburg, Germany; Kuno K. Kreuzer, Laureldale, Pa., Univ. of Heidelberg, Germany; John J. Poland, Cleveland, Univ. of Heidelberg, Germany; Richard S. Wegryn, Dayton, Univ. of Heidelberg, Germany; Oksana S. Czeredarczuk, Philadelphia, Pa., Univ. of Munich, Germany; Alexandra Shkolnik, Cleveland, Univ. of Munich, Germany; Elga Mazkalnins, Cleveland, Univ. of Munster, Germany; Ivan S. Alio, Columbus, Univ. of Tubingen, Germany;

John P. King, Dayton, Nat'l Univ. of Ireland; Hugh C. O'Connor, Toledo, Royal College of P. & S. of Ireland; Lino M. Lapenna, Columbus, Univ. of Bari, Italy; Joseph J. Bartolomeo, Syracuse, N. Y., Univ. of Bologna, Italy;

Kenneth J. Munden, Chicago, Ill., Univ. of Madrid, Spain; Basilio Gonzales, Cambridge, Univ. of Valencia, Spain; George C. Lakatos, New York City, Univ. of Berne, Switzerland; Harry Chovnick, Columbus, Univ. of Geneva, Switzerland; Charles P. Felton, New Orleans, La., Univ. of Geneva, Switzerland; Norman Pearl, New York City, Univ. of Geneva, Switzerland;

Elias A. Husni, Cleveland, American Univ. of Beirut, Lebanon; Zouhair Yassine, Cleveland, French Univ. of Beirut, Lebanon;

Ali Riza Dedehayir, Mansfield, Univ. of Istanbul, Turkey;

Carlos R. Diaz, Chicago, Nat'l Aut. Univ. of Mexico; German Oritz, Wheeling, West Va., Nat'l Aut. Univ. of Mexico; Elmer E. Raus, Fairfield, Nat'l Aut. Univ. of Mexico;

Eliseo M. Colli, Carroll, Ill., Univ. of Havana, Cuba;

Alfredo A. Ayala, W. Warwick, R. I., Nat'l. Univo of San Marcos, Peru.

Ohioans Covered By Hospital-Doctor Insurance Total 8,447,000

The number of people in Ohio covered by voluntary health insurance has reached a new high, the Health Insurance Council reports. The Council estimates that over 8,447,000 persons in the state now are protected by some form of insurance designed to help pay hospital and doctor bills.

The number of people covered by some form of health insurance in the nation, according to a Council estimate, is now 123,000,000, or 72 per cent of the total U. S. civilian population.

The Council survey, based on reports of insurance programs of insurance companies, Blue Cross-Blue Shield and other health care plans, points out that the 8,447,000 persons covered by hospital expense insurance in Ohio as of December 31, 1957, surpasses the 1956 year-end total of 8,181,000.

The number of people with surgical expense insurance, which helps to defray the cost of physicians' charges for operations, climbed to 6,941,000 as compared to 6,498,000 in 1956.

Persons protected by regular medical expense insurance, providing for doctor visits for nonsurgical care, rose to 4,318,000, compared to 3,587,000 the year before.

New Members of OSMA

The following are the names of the new members of the Ohio State Medical Association since August 1, 1958. The list shows the county in which they are affiliated, city in which they are practicing or temporary address in cases where physicians are taking postgraduate work.

Cuyahoga County (Cleveland unless otherwise indicated)
Albert E. Baldwin, Jr.
John R. Boswell
Charles M. Branden
Ying Chei Chen
Ivan Dimitroff
Roy J. Fischer
James H. Fry
Kingsbury G. Heiple
Robert M. Hess
L. Morris Jones
William E. Kincaid
Victor Koby
Ralph J. Kovach
Robert J. Lancaster
Amore Longano
Robert V. McMahon
Nancy B. Michael
Armand Moettus
Marie Pancner
Remberto Rangel
Lee I. Rubinstein
Vladimir Shkilnyk
Kathryn H. Svec
Thomas G. Geoghegan, Bedford

Franklin County
Henry P. Sengelmann, Columbus

Greene County
Harold J. Laughlin, Fairborn

Hamilton County
Edmund Strauss, Cincinnati

Harrison County
Samuel A. Chaney, New Athens

Huron County
William B. Elderbrock, Wakeman
William R. Graham, Wakeman

Lorain County
Howard H. Smead, Lorain

Mahoning County
Bernard Taylor, Youngstown

Miami County
Robert A. Rehm, Piqua
Dominic A. Thomas, Piqua

Summit County
George A. Miller, Jr., Akron

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W. C. U. Bldg. Quincy, Illinois

Central Ohio Heart Association Offers Fellowship Grants

Graduate students, physicians and investigators interested in heart research are invited to apply for fellowships now available from the Central Ohio Heart Association, 50 E. Broad St., Columbus.

Research grants are made to non-profit institutions in direct support of a particular investigator. Prospective investigators must apply for a specific program of research under their direction. Grants are awarded in support of research in the cardiovascular field or basic sciences related to it for periods of a year or more.

The Association is also taking applications for fellowships for research and training at Central Ohio institutions. Fellowships are available for one year and carry an annual stipend of from $4,800 to $7,000 a year.

A second type of fellowship, a clinical fellowship, is open to those with an M. D. and two years' residency. The clinical Donald Mahanna Fellowship is also open with the work being conducted at the Heart Station, University Hospital, Columbus. The stipend is $7,000 a year. Deadline for grant-in-aid applications is November 1, 1958, for fellowships starting July 1, 1959.

Physicians of Central Ohio Invited to Columbus Academy "Clinic Day"

Final plans for the second annual "Clinic Day" meeting of the Columbus Academy of Medicine have been announced.

This all day meeting on Saturday, November 1, will be held in the Veterans Memorial Building, 300 West Broad Street in Columbus.

Registration will be held from 8:30 until 9:30 A. M. with pre-registration necessary by Wednesday, October 29, by contacting Dr. Robert A. Heilman, Columbus Academy of Medicine, 79 E. State Street, Columbus 15, Ohio. The Registration cost will be $5.00 or $7.50 if luncheon is desired. Individual luncheons in the Post Meeting Rooms will be held with the guest speakers and will feature a question and answer period.

Physicians may be reached at CA 4-6116 for emergency telephone calls. Adequate parking facilities are located adjacent to the building.

The completed program has been announced as follows:

8:30—Registration

9:30—**Radiation Hazard in Medicine** — Paul

(Continued on Next Page)

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Potassium guaiacol sulfonate	70.0 mg.
Ammonium chloride	70.0 mg.
Menthol	1.0 mg.
Chloroform	0.02 cc.
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(Columbus Clinic Day—Continued)

Hodges, M. D., Professor of Radiology, University of Chicago, Chicago, Illinois

10:00—**Fat, Diet and Atherosclerosis**—Ray W. Gifford, M. D., Consultant, Section on Medicine, Mayo Clinic, Rochester, Minnesota

10:30—Coffee

11:00—**Newer Agents in Diabetes**—Rachmiel Levine, M. D., Chairman, Department of Medicine, Director of Metabolic and Endocrine Research, Michael Reese Hospital, Chicago, Illinois

11:30—**Prevention of Cancer, Forty Possible Means**—Robert J. Samp, M. D., Department of Surgery, Tumor Clinic, Wisconsin University School of Medicine, Madison, Wisconsin

12:00—Luncheon—Post Meeting Rooms, 2nd floor)

1:30—**Present Studies in Tissue and Organ Homotransplantation**—Joseph E. Murray, M. D., Director of Surgical Research Laboratories and Associate in Surgery, Harvard Medical School, Boston, Massachusetts

2:00—**Care of the Advanced Cancer Patient**—Panel Discussion

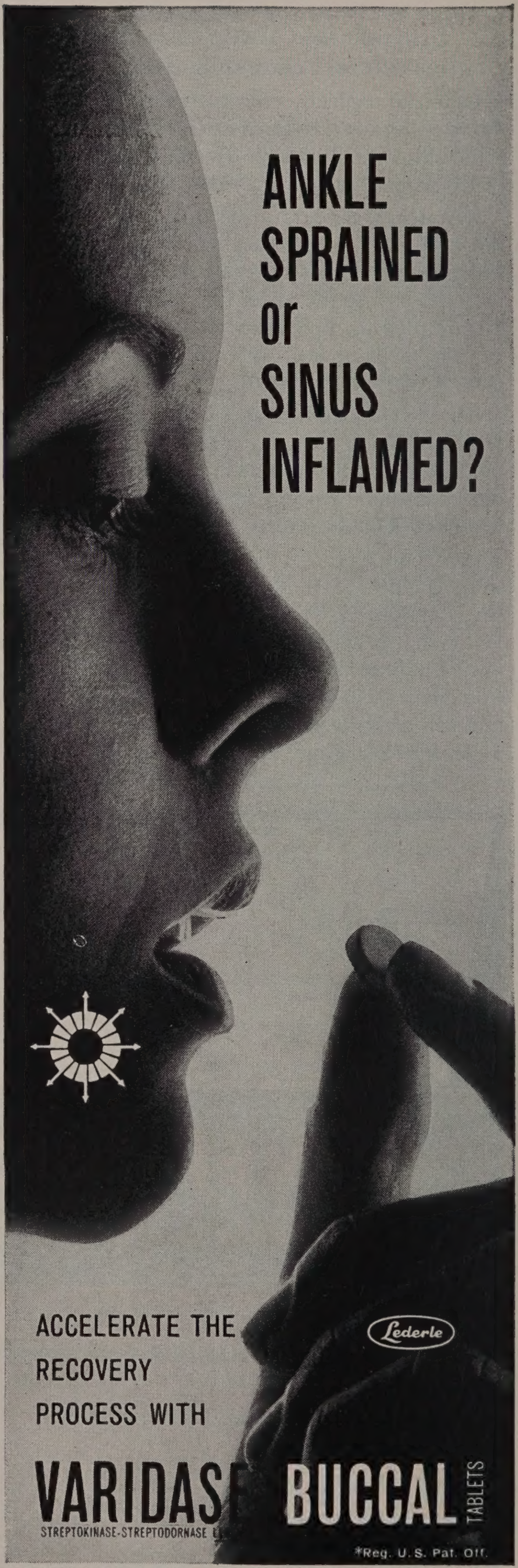
Moderator:
- Charles A. Doan, M. D., Dean, College of Medicine, Ohio State University

Collaborators:
- George T. Pack, M. D., Attending Surgeon, Memorial Hospital, New York City
- Chester Southam, M. D., Associate, Sloan-Kettering, New York City
- Bronson S. Ray, M. D., Professor of Neurosurgery, Cornell University, New York City
- James W. Carpender, M. D., Professor of Radiology, University of Chicago, Chicago, Illinois

4:00—Adjournment

The American Academy of General Practice has stated this program is acceptable for 4½ hours Category I Credit for its members. Interested physicians of other counties are cordially invited to attend.

Ralph Creer, director of motion pictures and medical television for AMA is to go to Tokyo next April as a guest of the Japan Medical Congress. Mr. Creer will organize and direct an International Medical Film Exhibition as part of the congress' 15th general assembly. He also will deliver several illustrated lectures to the faculty of the two medical schools in Japan.



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More Federal Aid To States For Civil Defense

Recent legislation which amends the Federal Civil Defense Act of 1950 provides for greater Federal leadership and financial assistance to the States in the development of civil defense plans and preparations. The following changes in existing procedures reflect the new concept of Federal responsibility:

The declaration of policy in the Federal Civil Defense Act is changed to make the responsibility for civil defense a joint one between the Federal Government and the several states and their political subdivisions. Heretofore, the Federal Government provided coordination and guidance while the responsibility was primarily that of the states and their subdivisions.

The Federal Government is authorized to purchase radiological instruments and detection devices such as Geiger counters and to grant them to the states. This authority is limited to a five-year period and not more than $35 million may be appropriated for this purpose in any one year.

The prohibition against Federal financial contributions to states for civil defense personnel and administrative expenses or for personal equipment for state and local civil defense workers is abolished. To be eligible for grants under this program, states must have approved civil defense programs consistent with the national plan, the plan must be state-wide and administered by a single state agency, employees must be under the merit system and there must be a full-time civil defense director or deputy director.

The former restriction against contributions to the states for the cost of personal equipment for state and local civil defense workers is eliminated in order to permit the Federal Government to bear a part of the cost of providing uniforms to persons performing police, fire and rescue work that they might be readily identifiable by the general public in an emergency.

Federal assistance would be subject to a 50 per cent contribution by the states and local governments toward administrative and personal expenses and the cost of items of personal equipment. The authority is limited to five years.

Appropriations for personnel and administrative expense contributions may not exceed $25 million per year and appropriations for contributions for items of personal equipment may not exceed $2 million per year.

A limitation of $100,000 on amounts appropriated annually for travel expenses and per diem allowances of persons attending civil defense schools is increased to $300,000. However, the states are required to bear one-half of these expenses whereas formerly the total cost was borne by the Federal Government within the $100,000 limitation. This authority is also limited to five years.

Two County Societies Hold Sports Injury Meets

The Lorain County Medical Society and the Portage County Medical Society have joined the list of local medical societies in Ohio which have conducted high school athletic injury conferences.

In August, both sponsored pre-season conferences for high school coaches throughout their respective counties, and both reported an enthusiastic reception.

The Lorain program is typical of the format used by the county societies in these conferences, and drew 78 persons representing school administration, athletic departments, Parent - Teacher Associations, referees and interested physicians.

Dr. Franklin H. Schaefer, Elyria, was moderator. Dr. Ben V. Myers, Lorain County Medical Society president, and C. A. Gibbons, county schools superintendent, introduced the purpose of the conference.

Built on areas of responsibility, the program included "Responsibility of the School Coach," by Joe Hudak, Amherst coach; "Responsibility of School Administration," by W. H. Jones, Avon schools superintendent, and "Responsibility of Physician and Dentist," by M. C. Kolczun, M. D.

In discussing specific injuries, their prevention, detection, immediate and long-time treatment, Dr. Conrad T. Rusin spoke on abdominal injuries, Dr. Joseph M. Strong, on injuries to extremities; Jack Underman, D. D. S., injuries to mouth and teeth, and Dr. Kolczun, injuries to head and face. The speakers then served as a panel for a question and answer session following the talks.

The society's planning committee for the conference included Drs. I. C. Riggin, chairman, Marion G. Fisher, W. H. Jones, Kolczun, L. C. Meredith and Dr. Schaefer.

The Portage County conference, which also included the athletic department at Kent State University, is to be an annual event if interest merits, and the Lorain County society has announced that its conference will be repeated in a similar or extended form if interest merits.

Physicians participating in the Portage County conference included Dr. E. A. Webb, chairman; Dr. T. Adamle (pre-season examination) Dr. R. Dumm (heart in athletics), Dr. R. McCormick (head and spine injuries), Dr. N. Chang (knee injuries), Dr. C. Voorhis (ankle injuries), Dr. J. Fiala (internal injuries), and Dr. C. Whitsett (x-ray and injuries).

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New timed-release tablet provides:

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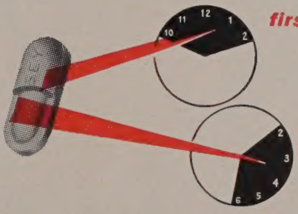

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Hospital Association To Present Institute on Infections

A one-day institute to present factual and useful information regarding the prevention and control of Staphylococcus infections in hospitals, has been announced for Wednesday, October 15, by the Ohio Hospital Association. The program will begin at 9:00 a. m. in the Hall of Mirrors, Deshler-Hilton Hotel, Columbus.

The OHA announced: "The Educational Committee and the Committee for this Institute, feel that this is a very serious problem for hospitals. Every hospital has a potential problem of infections and it appears that the number of such infections is increasing."

A registration fee of $10 per person includes the luncheon. The institute is of particular interest to hospital administrators, assistant administrators, operating room supervisors, chiefs-of-staff, directors of nursing and housekeepers. All physicians interested in the subject are invited. The program has been announced as follows:

Presiding at morning and afternoon sessions: Edgar O. Mansfield, superintendent, White Cross Hospital, Columbus.

Greetings—Roger Sherman, president, Ohio Hospital Association and administrator, Children's Hospital, Akron.

Introduction to the Problem, Dr. Peter A. Volpe, administrator, University Hospital, Columbus.

Medical Aspects of the Control of Infections, Dr. Kenneth M. Schreck, assistant professor of microbiology, School of Medicine, Temple University, Philadelphia. Discussion to follow.

Nursing Aspects of the Control of Infections, Jean Reed, R. N., operating room supervisor, University Hospital, Columbus. Discussion to follow.

Luncheon.

Administrative Aspects of the Control of Infections, Norman D. Bailey, Ph. D., executive director, Grant Hospital, Chicago.

Panel Discussion — Audience Participation, Dr. Volpe as moderator, with the foregoing speakers as members of the panel.

Summary, Mr. Mansfield.

Presentation of Certificates.

William Hetherington, executive publisher of the AMA magazine, *Today's Health,* has resigned to accept a post with *Reader's Digest.*

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In Memoriam . . .

Ralph W. Beede, M. D., Youngstown; Ohio State University College of Medicine, 1937; aged 63; died August 19; former member of the Ohio State Medical Association; member of the American Academy of General Practice. A native of Youngstown, Dr. Beede served all of his professional career there. He was a member of the Methodist Church, the PSA, a national photography association, and the American Rose Society. Surviving are his widow, a son, three brothers and two sisters.

Frank W. Case, M. D., Cincinnati; Miami Medical College, Cincinnati, 1907; aged 75; died August 25; member of the Ohio State Medical Association. Dr. Case practiced his profession in Cincinnati for nearly 50 years. He was a member of the Episcopal Church. Surviving are his widow, a daughter, and a son, Dr. Victor Case, who was associated with his father in practice.

George T. Flesher, M. D., Huntington, West Virginia; Medical College of Virginia, 1934; aged 51; died August 14; former member of the Ohio State Medical Association; diplomate of the American Board of Otolaryngology. Dr. Flesher formerly practiced in Columbus and in Willard. A daughter survives.

Francis F. Heyroth, M. D., Ph. D., Cincinnati; University of Cincinnati College of Medicine, 1925; aged 63; died August 17; member of the Ohio State Medical Association and the American Medical Association; member of the American Chemical Society; Dr. Heyroth retired in 1957 as assistant director of the Kettering Laboratory and associate professor of industrial toxicology and biological chemistry at the University of Cincinnati. A former vice-president of the Cincinnati Board of Health, his appointments included those on the National Advisory Dental Research Council of the U. S. Public Health Service and on the National Research Council panel on environmental cancer. Surviving are his widow and two daughters.

Lucy Michaelis, M. D., Cleveland; Friedrich-Wilhelms University Faculty of Medicine, Berlin, 1922; aged 61; died August 19; member of the Ohio State Medical Association and the American Medical Association. Born and educated in Germany, Dr. Michaelis had been a practicing physician in Cleveland since 1939.

Hurston H. Morris, M. D., Portsmouth; Marquette University School of Medicine, 1926; aged 62; died August 26; former member of the Ohio State Medical Association. Dr. Morris began his practice in Fullerton, Ky., and moved to Portsmouth in 1930. His widow survives.

Franklin H. Pennell, M. D., Fostoria; Ohio State University College of Medicine, 1920; aged 63; died August 18; member of the Ohio State Medical and the American Medical Association. A native of Fostoria, Dr. Pennell served all of his professional career there. He was active in numerous civic and community affairs of the area; was a member of the Rotary Club, the Red Cross, the Masonic Lodge, the Fostoria Country Club and the Methodist Church. A veteran of World War I, he was a member of the American Legion. Surviving are his widow, a daughter and a son.

Francis S. Schwarz, Jr., M. D., Cleveland; Cornell University Medical College, 1943; aged 37; died August 31 in a traffic accident; member of the Ohio State Medical Association, the American Medical Association and the American Academy of Ophthalmology and Oto-Laryngology; diplomate of the American Board of Ophthalmology. Dr. Schwarz began his practice in Cleveland in 1950. He is survived by his widow, his parents, a brother and two sisters.

Paul S. Williams, M. D., Santa Cruz, Calif.; Western Reserve University School of Medicine, 1931; aged 52; died August 27; former member of the Ohio State Medical Association. Dr. Williams practiced in Hubbard until about 10 years ago when he moved to Phoenix, Arizona. He moved recently to California. His widow survives.

John Francis Wright, M. D., Toledo; University of Wooster Medical Department, Cleveland, 1903; aged 78; died August 12; member of the Ohio State Medical Association and the American Medical Association; recipient of the OSMA 50-Year Award; former delegate of the Academy of Medicine of Toledo to the OSMA. Dr. Wright served all of his professional career in the Toledo area with the exception of time served in the Medical Corps during World War I. He was a member of St. Mary's Church of Toledo, and the American Legion. Survivors include his widow; a son, Dr. John J. Wright; a daughter, and two sisters.

Richard Stalvey, of the AMA Public Relations Department, has taken up his new duties as assistant executive director of the Los Angeles County Medical Society.

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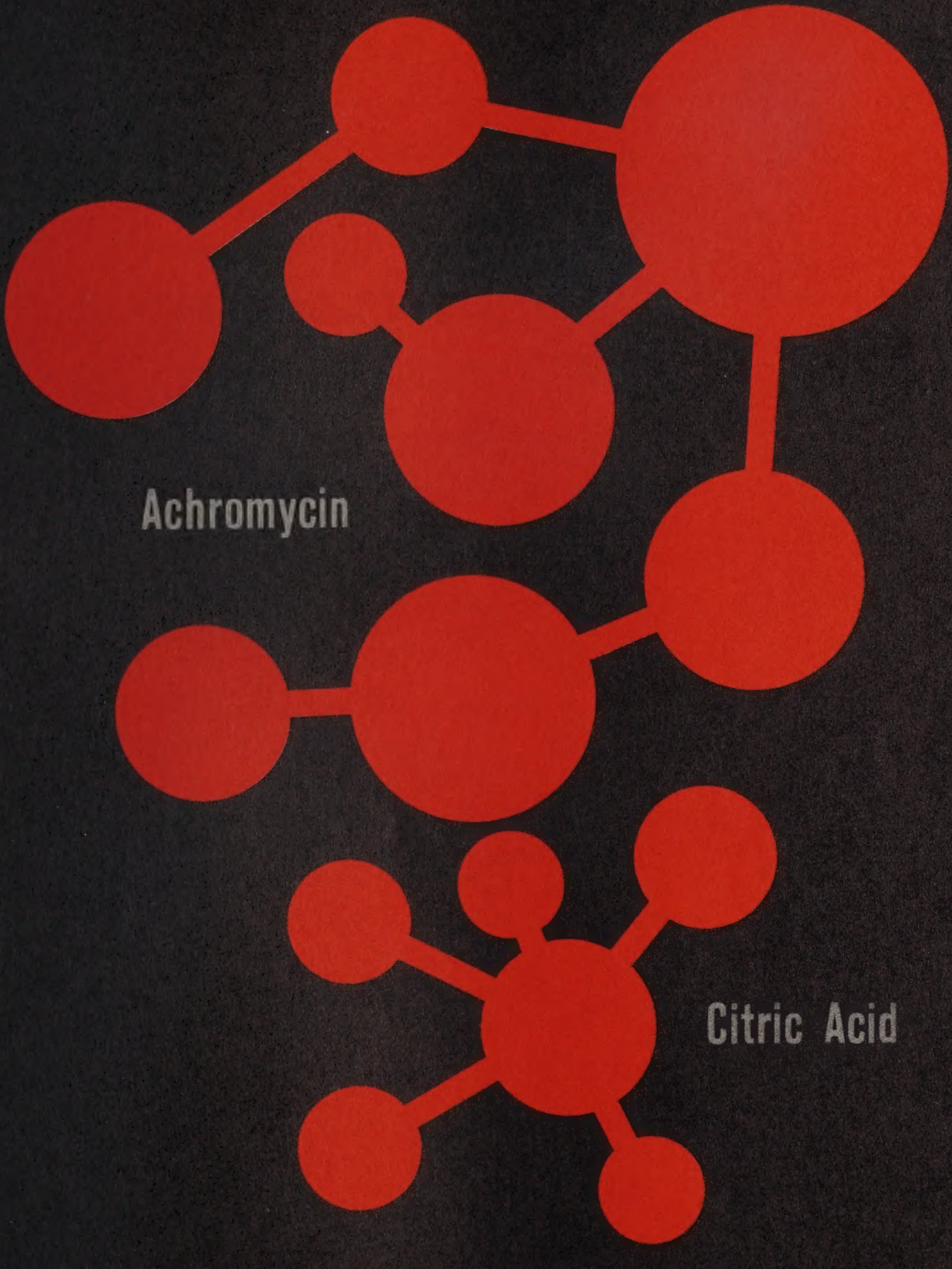
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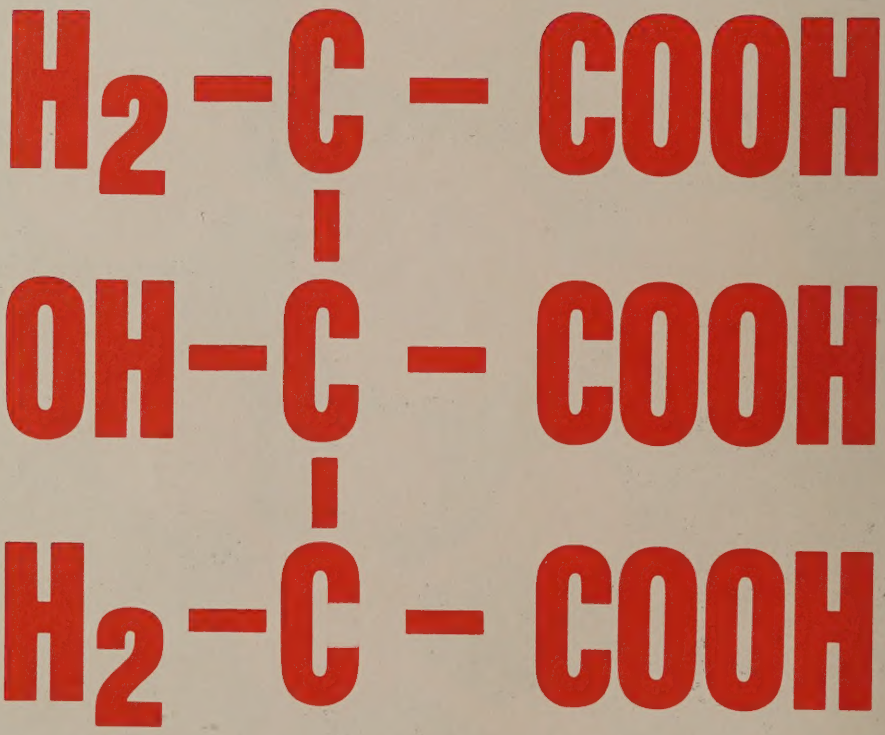

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In developing ACHROMYCIN V, Lederle research scientists aimed for patient response rather than laboratory results, and chose citric acid for its outstanding value under clinical conditions. Citric acid is unique in that it contains THREE free carboxyl groups in every molecule to combine with the metallic ions which interfere with gastrointestinal absorption. This activity thus leaves the pure active tetracycline molecule available for full absorption and rapid action at the site of infection.

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ASSURES EVERY PATIENT PRECISE ANTIBIOTIC ACTION UNDER THE VARIED CONDITIONS OF REALISTIC CLINICAL PRACTICE

produces optimal gastric conditions

Ideally, most antibiotics are given on an empty stomach. Since citric acid helps control unfavorable variances in gastric content,conditions in the stomach are optimal with ACHROMYCIN V tetracycline with citric acid.

prevents interference with absorption

Sequestering of antibiotic molecules by free metallic ions, always present in the intestinal tract, can deprive patients of a full therapeutic dose. The three active carboxyl radicals which protect the action of ACHROMYCIN V trap these free cations and allow uninhibited antibiotic absorption.

provides for peak antibiotic action

At the site of infection where, in essence, all antibiotics are proved, ACHROMYCIN V combats a wide range of pathogens under optimal tissue conditions. Citric acid, a factor of medically established value in the natural acid-base regulating mechanism of the G.I. tract, facilitates a more complete, and rapid antibiotic action.

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Some WC Fees Increased . . .

Raises Granted by Bureau Less Than Recommendations of OSMA; New Schedule Is Effective for All Services Rendered on or After October 1

A NUMBER of items in the Bureau of Workmen's Compensation Fee Schedule have been increased for services rendered by physicians in BWC cases on and after October 1, 1958.

The principal increases are in fees for first treatment at home, office and hospital and subsequent treatments at office and home.

The Bureau and the State Industrial Commission did not increase the fees to the extent requested by the Ohio State Medical Association through the Council and the Committee on Industrial Health and Workmen's Compensation.

Representatives of the Association had held a number of conferences on the subject with officials of the BWC and the State Industrial Commission. Statistical information was presented substantiating the Association's requests. This included data on the increased cost of practicing medicine, including office personnel, rent, dressings, drugs, etc.

Comparison Tabulation

The following tabulation shows fees prior to October 1, 1958; amounts recommended by the Ohio State Medical Association; and the fees set by the Bureau, effective October 1, 1958:

	Prior To October 1, 1958	Asked By OSMA	Granted By Bureau
First treatment at office (day)	$5.50	$7.00	$6.00
First treatment, home or hospital (day)	7.00	8.00	7.50
First treatment, office, home, hospital (night emergency 9 PM to 7 AM) (Also requested that "9 PM" be changed to "8 PM.")	9:00	10.00	9.00
Subsequent treatment at office, including ordinary medication and dressings	3.00	4.00	3.25
Subsequent treatment at home, including ordinary medication and dressings	4.00	5.00	4.25
Subsequent treatment at hospital	3.50	4.00	3.50
Mileage beyond corporation limits, per mile one way	.50	.60	.50
Tetanus antitoxin (prophylactic) in addition to the regular treatment fee	2.00	3.00	3.00
Gas bacillus and tetanus antitoxin combined (prophylactic)	3.00	4.00	4.00

Anesthesia Fee Increased

Acting on a request from the Ohio Society of Anesthesiologists for more adequate compensation for the administration of anesthesia during prolonged operations, the fee schedule for anesthesia was revised by eliminating the item "Second thirty minutes or fraction thereof, $10.00" and substituting the item "Each additional thirty minutes or fraction thereof, $10.00."

Statement by Administrator

Commenting on his decision and that of the State Industrial Commission, James L. Young, BWC Administrator said:

"We feel that the increases as granted are commensurate with the present economic situation and the proper administration of the Workmen's Compensation Act."

Mr. Young estimated that the increases granted would add approximately $750,000 annually to the amount paid to Ohio physicians for the treatment of industrial accident cases. Payments to physicians in 1957 amounted to $7,827,104.24.

Fee Schedule Additions

The following items, not previously listed, were added to the BWC Fee Schedule, at the request of Dr. Addison L. KeFauver, Chief Deputy Administrator of BWC. The fees had been approved as recommended by the OSMA Committee on Industrial Health and Workmen's Compensation.

Genitourinary Procedures

*Catheter, insertion and replacement of, on home visit (in addition to regular treatment fee and including cost of catheter) $10.00

Laboratory Procedures

*Fungus, culture for (in addition to regular treatment fee) $ 5.00

(Continued on Page 1352)

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Neurosurgical Procedures

Lobotomy, transorbital	$100.00
Lobotomy, prefrontal	$200.00

Ophthalmological Procedures

Glaucoma, operation for	$175.00
Extraocular muscles, primary operation on:	
One muscle	$100.00
More than one muscle	$150.00

Surgical (Orthopedic)

Arthrogram, injection of contrast for (exclusive of roentgenographic study)	$ 25.00

Surgical Procedures

Saphenous vein ligation and complete stripping:	
Unilateral	$150.00
Bilateral	$200.00
Pneumonectomy	$300.00
Lobectomy	$300.00
Splenectomy	$200.00

Miscellaneous

*Proctoscopy and/or sigmoidoscopy (in addition to the regular treatment fee)	$ 10.00

Corrections Made

In two items in the old Fee Schedule the asterisk, indicating that the fee allowed is in addition to the regular treatment fee had been inadvertently omitted. As corrected in the new fee schedule these items are as follows:

*Superficial x-ray therapy	$5.00
*Corneal scar, treatment of, by beta-radium	$5.00

Copies To Be Sent To Members

The Bureau of Workmen's Compensation is having a new booklet printed containing the revised Fee Schedule, rules and regulations governing the filing of claims and general information for physicians, dentists and hospitals on administrative procedures. When available, a copy of this booklet will be mailed to each member of the OSMA with an issue of *The OSMAgram.*

"Story Behind the Word" Book Published by Dr. Wain

Readers of *The Journal* will be interested in knowing that a book, *The Story Behind the Word,* has been produced by Dr. Harry Wain, Mansfield. It has been published by Charles C. Thomas, Springfield, Ill. The cost at bookstores is $8.50. The book is an alphabetical compilation of 5,700 derivations of medical terms, many of which appeared in *The Ohio State Medical Journal* during the past ten years when Dr. Wain authored *The Story Behind the Word* column of *The Journal.*

Columbus Heart Program Will Stress The Role of the Radiologist

"The Radiologist's Role in Cardiology" will be the subject of Dr. Stanley M. Wyman, chief radiologist of the Massachusetts General Hospital, when he speaks to the Scientific Council of the Central Ohio Heart Association, November 5, at 3 p. m.

All Central Ohio physicians are invited to attend the all-day session, Room-100, Starling-Loving Hospital, Ohio State University.

The program will begin at 10 a. m. with an exhibit by the OSU Department of Radiology. There is also a business meeting of the Scientific Council at 10 a. m. This will be followed at 11 a. m. by Case Rounds. Physicians are invited to send a brief summary of an interesting cardiac problem to Dr. Sidney Nelson at Heart Association, 50 E. Broad St., Columbus. The summary must be in by October 15, and include P-A and lateral films of the chest, thick Barium swallow with films: (1) frontal (2) lateral and (3) right and left posterior oblique.

The Case Rounds, which will continue after luncheon, will be a panel moderated by Dr. Wiley Forman with Dr. Wyman, Dr. Sidney Nelson, chief of radiology at OSU; Dr. William Molnar, associate professor of radiology at OSU; Dr. William Howard, chief of radiology at Children's Hospital, and Dr. Paul Jones, president of the Ohio State Radiological Society as panel members.

Farmers Moving Ahead on the Amount Spent for Health Protection

The American farmer is rapidly catching up to the city dweller in the amount of money he spends to protect his health, according to the Health Insurance Institute, citing a survey conducted jointly by the U. S. Department of Agriculture and the U. S. Bureau of the Census.

The government study showed that in 1941 farm families spent an average of $15 a person for medical care, less than half the $32 spent for members of urban families. But in 1955, the individual spending level for farmers was $63, or nearly 80 per cent of the estimated $81 laid out by city folk.

The report shows that the average farm family spent $60 for medical care in 1941. In 1955, the sum was $235, which is the equivalent of $126 in 1941 when the change in price level is taken into account.

In 1955, the report stated, some 51 per cent of farm families had some form of health insurance.

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Vitamin B-1	2.5 mg.
Vitamin B-2	2.5 mg.
Vitamin B-6	1 mg.
Vitamin B-12 Activity	3 mcg.
Panthenol	5 mg.
Nicotinamide	20 mg.
Folic Acid	0.1 mg.
Biotin	30 mcg.
Rutin	12 mg.
Calcium Carbonate	125 mg.
Boron	0.1 mg.
Cobalt	0.1 mg.
Fluorine	0.1 mg.
Iodine	0.2 mg.
Magnesium	3.0 mg.
Manganese	1.0 mg.
Molybdenum	1.0 mg.
Potassium	2.5 mg.

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Activities of County Societies . . .

CLERMONT

On September 17 the Clermont County Medical Society met at the DX Ranch with Dr. Carl Minning as host. The speaker was Dr. Homer Kohler, Cincinnati, who spoke on "Urinary Stones."

DARKE

The annual fall meeting of the Darke County Medical Society was held at the Greenville Country Club on September 16. A social hour was followed by dinner. After-dinner speaker was Harold Pickett, humorist.

HAMILTON

The annual meeting of the Academy of Medicine of Cincinnati was held on September 23 at the Roof Garden of the Sheraton-Gibson Hotel, where a complimentary smorgasbord was served by the Chas. Pfizer and Company, preceded by a social hour.

Dr. Jerome J. Van Gasse spoke on the subject "The Physician's Role in Living Science."

New president of the Academy is Dr. J. Robert Hudson, who assumed office to succeed Dr. George X. Schwemlein. President - Elect, who will take office as president in September, 1959 is Dr. Clyde S. Roof.

LORAIN

During the month of June the Lorain County Medical Society sponsored a special "Polio Prevention Campaign."

Using the material offered by Eli Lilly and Company, and through the cooperation of businesses, industry, civic centers and its own membership, the Society distributed throughout the county: 50 sandwich board type posters; 150 easel type posters; 15,000 leaflets or envelope stuffers; newspaper mats and 100 window or door stickers.

The County and Elyria and Lorain City Health Departments were most helpful in this effort and to remind the citizens of Lorain County of their responsibility in securing the necessary polio shots.

Lorain County was glad to report that as of late August there were no new polio cases this year.

The September 9 meeting of the Lorain County Medical Society was held at the Oberlin Inn. The Ladies Auxiliary was invited as a kick-off for their membership drive; 125 physicians and wives were present. Dr. William B. Wladecki and Dr. Ward Young, both of Elyria, were elected to active membership.

Formal reports were given by the chairmen of standing and special committees, and these revealed significant gains had been made in furthering public relations. Especially effective was the School Health Committee, (chairman Dr. I. C. Riggin) which organized and presented a well attended joint conference for prevention of injuries in the High School athlete. Significant rapport between the County Society and the County Commissioners was established through the action of a special Liaison Committee on Welfare.

A Clambake for all physicians and wives was announced for late September.

Dr. George G. Thomas, head of the Anesthesia Department of St. Francis Hospital, Pittsburgh, Pa. has been scheduled to present a program on explosive hazards in the hospital at the October 14 meeting.—Lawrence C. Meredith, M.D., Secretary-Treasurer.

PORTAGE

The regular August meeting of the Portage County Medical Society was held on the 20th at Green Trees Inn, Twin Lakes. After luncheon Mr. Frank Caulkins of the Professional Management of Cleveland, spoke on "Medical Economics of the Future."

The Portage County Medical Society sponsored an Athletic Injury Conference in the Health and Education Building of Kent State University, Kent, on August 19. The following persons participated, speaking on the subjects indicated: Dr. E. A. Webb, chairman; Dr. T. Adamle, "Pre-Season Examination"; Dr. R. Dumm, "The Heart in Athletics"; Dr. R. McCormick, "Head and Spine Injuries"; Dr. N. Chang, "Knee Injuries"; Dr. C. Voorhis, "Ankle Injuries"; Dr. J. Fiala, "Internal Injuries"; Dr. C. Whitsett, "X-Ray and Injuries." Mr. Begala, Kent State trainer, gave the trainer's slant on the subject.

Additional report on this conference will be found on page 1344 of this issue.

SCIOTO

At the regular September meeting of the Scioto County Medical Society a film, "Grand Rounds No. 7—Current Therapy of Diabetes," was shown as part of the program. Another feature was a review of 1958 Convention Highlights.

TRUMBULL

The Trumbull County Medical Society's first meeting of the new year was held at the Squaw Creek Country Club on September 17 with dinner and an evening program. The Auxiliary also shared in the event.

Dave Dennison, representative to Congress from the 11th Congressional District, was guest speaker and discussed the topic, "Recent and Pending Legislation Affecting the Practice of Medicine."

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Write for additional information regarding other uses which include management of hiccup and reflex vomiting, as well as relief of discomfort associated with laryngoscopy, esophagoscopy, gastroscopy and the passage of esophageal and gastric tubes.

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Activities of Woman's Auxiliary . . .

Ohio Auxiliaries Receive Honors At San Francisco Meeting

The thirty-fifth annual convention of the Woman's Auxiliary to the American Medical Association was held in San Francisco, California, June 23-27, at the Hotel Fairmont. Registration was 2,155 with representatives from practically every component state auxiliary including Alaska and Hawaii.

Preceding the formal opening of convention on Tuesday, 23 Ohio delegates met for the traditional Ohio Breakfast in the Garden Room of the Hotel Fairmont. Of the 47 delegates and 8 alternates elected, plus the presidential delegate, 35 registered at the convention. All alternates were raised to the status of delegate. Ohio was second in attendance when roll call was taken at the opening session.

Again Ohio has been nationally recognized as Mrs. William H. Evans, Youngstown, was elected a director for a term of two years; Mrs. Karl F. Ritter, Lima, appointed national chairman of the American Medical Education Foundation and Mrs. V. R. Frederick, Urbana, is the regional chairman of Community Service or Public Relations.

Ohio State Auxiliary won two awards:

1. Top Award in *Today's Health*—Ohio was the winner of the 1957-58 National Auxiliary Subscription Project in Group IV. In other words, Ohio won over every other Auxiliary whose membership exceeds 3001 members. The prize was $40.00. The State average for counties over 100 per cent was 8. Ohio had 25.

2. An Award of Merit for outstanding contribution to the American Medical Education Foundation. The Ohio total contribution to the AMEF was $15,069.67—a contribution of $3.00 per member. Ohio was one of 10 states receiving the Award of Merit and four of Ohio's county auxiliaries received certificates of achievement.

The Roundtables of Monday, June 23 gave the delegates an opportunity to hear the Auxiliary chairmen discuss timely and important Auxiliary topics. A tea and fashion show, Monday afternoon, honored Mrs. Paul C. Craig, president and Mrs. E. Arthur Underwood, president-elect.

The formal opening of the convention was on Tuesday, June 21. Following the introductory procedure of the convention, reports were given. Luncheon on Tuesday was in honor of the past-presidents of the Woman''s Auxiliary to the American Medical Association with Mr. Richard H. McFeely, principal of the George School, Bucks County, Pennsylvania, as guest speaker. The afternoon session featured State Projects reports as well as the reports of National Committee chairmen. The first reading of the nominating committee was given and the 1959 nominating committee was elected by ballot.

On Wednesday another general meeting was held. More reports were heard and the new by-laws were adopted by the convention. A few of the changes are as follows:

1. Instead of second to fifth vice-presidents, they are now named regional vice-presidents. Also the finance secretary, historian, and parliamentarian are now appointed officers.

2. Under committees, by-laws instead of revisions; community service instead of public relations; membership instead of organization; paramedical careers rercuitment instead of recruitment; addition of a new committee—reports; and that all committees are now standing committees.

3. Representation by the states at the National Convention in addition to the president of each constituent auxiliary or, in the absence of the president, the president-elect, one representative from each constituent auxiliary for each 300, or major fraction thereof, paid members in good standing in the National Auxiliary rather than one for each 100 or major fraction thereof.

4. The slate of the nominating committee shall be included in the call to the annual convention.

The luncheon on Wednesday honored Mrs. Paul Craig and Mrs. E. Arthur Underwood, and the guest speaker was Dr. David B. Allman, Immediate Past-President, American Medical Association. Following was the presentation of the Woman's Auxiliary contribution to the American Medical Education Foundation; the presentation of the AMEF Awards and the AMEF Certificates of Achievement. The new paramedical careers film "Helping Hands for Julie" was shown in the afternoon, after which several roundtable discussions were conducted.

Thursday concluded the convention and at this session the new National officers were elected and installed. Mrs. E. Arthur Underwood gave an inspiring inaugural address. Mrs. Underwood's theme for the year is "Safeguard Today's Health for Tomorrow."

The Woman's Auxiliary to the American Medical Association has become incorporated "not for profit" in the State of Illinois. A copy of the articles of incorporation will appear in the new

(Continued on Page 1358)

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references:

1 Grieble, H.G., and Jackson, G.G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958

2. Editorial: *New England J. Med.* 258:48-49, 1958.

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(Continued from Page 1356)

printed by-laws. The name is the Woman's Auxiliary to the American Medical Association, Inc. It is a federacy of its constituent auxiliaries and hereafter will be referred to as the National Auxiliary.

* * *

Fall Conference

The Woman's Auxiliary to the Ohio State Medical Association held its fourteenth annual conference on September 8 and 9.

The first day was used as a dress rehearsal for participants for the Fall Conference and the State Board Meeting.

On Tuesday the 9th, county presidents, officers, chairmen, members-at-large, and State Board members came to the Deshler-Hilton Hotel in Columbus to exchange ideas in preparation for Auxiliary work in the coming year.

Mrs. C. H. Bell, president, called the meeting to order at 9:30 a.m. She greeted members and spoke briefly of Ohio's splendid record as reported at the National Convention in San Francisco in June. Mrs. Bell then reminded members they were here to: "Decide where we are going. What we are doing, and, How we are to accomplish our plans."

She urged all to make the meeting enjoyable and educational.

Mrs. Bell introduced Mrs. C. A. Colombi, president-elect, who had charge of the Conference. Mrs. Colombi reminded members that the theme for the year is "Safeguard Today's Health for Tomorrow." She concluded her remarks with these words: "Coming together is a beginning, Keeping together is progress, Thinking together is Unity, Working together is success."

The 183 registered members representing 42 counties then adjourned to conference rooms for meetings with State officers and Committee chairmen. Instructions were given and ideas exchanged which will make for better working Auxiliaries in the year ahead.

A luncheon was held in the Grand Ballroom with Mrs. C. H. Bell presiding. Honor guests were: Dr. George A. Woodhouse, President of the Ohio State Medical Association; Mr. Charles S. Nelson, OSMA Executive Secretary; Mr. George H. Saville, OSMA Director of PR; The Reverend Paul Johnston, and State officers of the Woman's Auxiliary to the OSMA.

Mr. Nelson spoke briefly on legislative problems. He urged all to participate in a plan to get citizens registered, to study the candidates' platform, and to vote.

Dr. Woodhouse was the principal speaker. He brought greetings from the Ohio State Medical Association and congratulations for the splendid record of the Woman's Auxiliary and for the National recognition received at the Convention in San Francisco. He asked the Auxiliary to continue supporting the Ohio State Medical Association in its important projects namely: The American Medical Education Foundation, *Today's Health* and Help for the Aged.

Mrs. Charles Harding and Mrs. Ben Arnoff of Franklin County served as chairman and co-chairman of the Conference.

The next State Board meeting will be held January 15 at the Deshler-Hilton Hotel in Columbus.

A 16 per cent decrease in the average daily number of tuberculosis patients in Veterans Administration hospitals since 1954 was reported by the agency. The daily average dropped from 15,221 in fiscal year 1954 to 12,715 in fiscal year 1957, although the number of admissions and discharges remained the same. Decrease was attributed to a reduction of length of stay due to improved drug treatment.

ANNUAL CLINICAL CONFERENCE

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Sterilization and Abortion . . .

Legal and Ethical Aspects Discussed; Facts and Comments Compiled From Reliable Sources Are Assembled; Consultation With Lawyer Suggested

WHAT are the legal and ethical aspects relative to operations to produce sterility and the performance of abortions? Among the many and varied inquiries which reach the Columbus Office, this question is not uncommon.

In this article will be found facts and suggestions on these two subjects. This article should not be construed as a legal opinion—merely a review of basic facts and comments from various reliable sources. Individual physicians when they need advice on subjects such as these should confer with their own lawyer and be guided by the attorney's advice. The data here will serve as a background and should alert the physician to seek legal advice when in doubt of his status.

Ohio Law is Silent

There is no law in Ohio pertaining to sterilization, or tubal ligation.

Legal authorities are in disagreement as to whether or not a physician in Ohio may legally perform a sterilization operation, even with the written consent of the patient, when there is no definite permission granted by statute for him to do so.

Several years ago one legal authority stated "that in the absence of any law making it a crime for a physician to perform vasectomy upon an individual of sound mind with his consent, such an operation may be performed by a physician."

Other legal authorities take the opposite view, holding that in the absence of a statute making it legal for a physician to perform a sterilization operation with the consent of the individual, that a physician has no legal right to perform such an operation under any circumstances.

Some contend that the performance of a sterilization operation on an individual, with his consent, may not be illegal per se but that the performance of the operation may be a violation of general statutes pertaining to technical assault, especially the provision relating to "maim." As one authority points out, a person "may kill or injure himself by evil practice but he may not maim himself or arrange with another person to maim him."

Webster's New International Dictionary gives the following definition for maim: "Privation of the use of a limb or member of the body; a crippling; serious physical injury; hence, deprivation of something essential; a serious defect or blemish."

Section 2901.19 of the Ohio Revised Code reads as follows:

"No person shall with malicious intent to maim or disfigure, cut, bite or slit the nose, ear or lip, cut out or disable the tongue, put out or destroy an eye, cut off or disable a limb or member, of another, or throw or pour upon or throw at another scalding water, or assault another with a dangerous instrument. Whoever violates this section shall be imprisoned not less than three years nor more than thirty years. Whoever, with like intent, throws upon the person of another oil or vitriol or other corrosive acid, or caustic substance, so as to disfigure the person, may be imprisoned for life."

In the foregoing section the words "malicious intent" are used. Although the average person interprets "malicious intent" to mean a desire to injure or damage someone because of a dislike, or to repay some offense committed by the second person, these words might be interpreted by the court to mean premeditation or the fulfillment of an act planned in advance and having a specific purpose.

Public Policy

A number of authorities have argued that sterilization or depriving a person of his or her powers of procreation is an offense against public policy. One authority states, "Whatever ethical reasons may be advanced in favor of such operations in certain cases, in law they amount to illegal maiming. If this practice became general, the future of the race would be imperiled."

Other authorities have held that sterilization done with the consent of the individual and by specific contract with him, is not against public policy.

Some who have engaged in the argument also say the question must be viewed from the standpoint of medical ethics and the obligation which the physician owes his patients. One authority points out that some physicians consider sterilization justifiable as a prophylactic measure to avoid a pregnancy or series of pregnancies certain to be difficult or dangerous. This authority states that while there are good arguments in favor of sterilization in such instances, that there are other

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—the remarkably efficient skeletal muscle relaxant, unique in chemical formulation, and outstanding for sustained action and relative freedom from adverse side effects.

PUBLISHED REFERENCES: 1. Carpenter, E. B.: Southern Medical Journal 51:627, 1958. 2. Forsyth, H. F.: J.A.M.A. 167:163, 1958. 3. Little, J. M., and Truitt, E. B., Jr.: J. Pharm. & Exper. Therap. 119:161, 1957. 4. Morgan, A. M., Truitt, E. B., Jr., and Little, J. M.: J. Am. Pharm. Assn., Sci. Ed. 46:374, 1957. 5. O'Doherty, D. S., and Shields, [illegible] D.: J.A.M.A. 167:160, 1958. 6. Park, H. W.: J.A.M.A. 167:168, 1958. 7. Truitt, E. B., Jr., and Patterson, R. B., Proc. Soc. Exper. Bio. & Med. 95:422, 1957. 8. Truitt, E. B., Jr., Patterson, R. B., Morgan, A. M., and Little, J. M.: J. Pharm. & Exper. Therap. 119:189, 1957.

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Summary of four new published clinical studies:

Robaxin Beneficial in 95.6% of Cases of Acute Skeletal Muscle Spasm[1, 2, 5, 6]

CONDITION	NO. PATIENTS	RESPONSE			
STUDY 1[1]		"marked"	moderate	slight	none
Skeletal muscle spasm secondary to acute trauma	33	26	6	1	—
STUDY 2[2]		"pronounced"			
Herniated disc	39	25	13	—	1
Ligamentous strains	8	4	4	—	—
Torticollis	3	3	—	—	—
Whiplash injury	3	2	1	—	—
Contusions, fractures, and muscle soreness due to accidents	5	3	2	—	—
STUDY 3[5]		"excellent"			
Herniated disc	8	6	2	—	—
Acute fibromyositis	8	8	—	—	—
Torticollis	1	—	—	1	—
STUDY 4[6]		"significant"			
Pyramidal tract and acute myalgic disorders	30	27	—	2	1
TOTALS	138	104 (75.3%)	28 (20.3%)	4	2

THE JOURNAL
American Medical Association

"In the author's clinical experience, methocarbamol has afforded greater relief of muscle spasm and pain for a longer period of time without undesirable side effects or toxic reactions than any other commonly used relaxants . . ."[2]

THE JOURNAL
American Medical Association

"An excellent result, following methocarbamol administration, was obtained in all patients with acute skeletal muscle spasm."[5]

THE JOURNAL
American Medical Association

"In no instance was there any significant reduction in voluntary strength or intensity of simple reflexes."[6]

Southern Medical Journal

"This study has demonstrated that methocarbamol (Robaxin) is a superior skeletal muscle relaxant in acute orthopedic conditions."[1]

methods of avoiding conception available and that even therapeutic abortions might be deemed more advisable than an operation which would end for all time the patient's ability to procreate, when the sterilization is contemplated in the case of a woman.

The question of voluntary sterilization and the question of birth control are closely associated and, aside from the legal angles involved, the physician who may be asked to perform such an operation is confronted with the responsibility of making a decision between surgery as a method of birth control and other measures which can be used to avoid pregnancy.

Even though it might be held in court proceedings that a sterilization operation is justifiable for therapeutic purposes and in instances where childbirth would be detrimental to the health of the wife or might result in the birth of abnormal children, on the other hand, there is a widespread belief that courts or juries would not be very sympathetic to sterilization operations performed merely for "convenience."

The Human Element

If both parties consent to the operation it would seem as if no litigation would take place. On the other hand, the physician can never be sure and it might be at some future time one or both parties would regret their original agreement and might blame the physician for having either urged the operation or consented to perform it.

It is readily seen that this is a moot question. For this reason any physician undertaking a sterilization operation, should be very careful in establishing all possible safeguards. In other words, in the case of a single man or woman, he should have the consent, in writing, of the patient and perhaps have the document witnessed by someone next of kin. In the case of a married man or married woman, the contract of permission should be signed by both the man and wife. Such contracts should set forth clearly the reasons presented by the patient for wanting such an operation. Such documents would be of great value in case of subsequent litigation, and the physician might find himself in a bad way if he could not submit them in his defense.

Recently, in its "Medicine and the Law" department, *The Journal of the AMA* offered these comments regarding sterilization:

"In the absence of specific statutes and court decisions on the subject, the circumstances in which a person can give a valid consent to an operation of this kind are not too clear. While consent is doubtless valid if the operation is necessary to relieve or cure some existing disease or safeguard the life of the patient, the validity of a consent to an operation that is not required for any therapeutic reason nor performed in accord with statutes relating to eugenic sterilization would at least be open to question.

"The law is still not settled, and the question of the physician's legal liability for the performance of an operation to produce sterility in the absence of therapeutic necessity is not clear. In any case, the physician before proceeding with any operation that will produce sterility should obtain from the patient or his parent and from the spouse of a married patient written consent in a form that shows the patient or parent and the spouse have consented with full knowledge of the purpose of the operation and its effects."

Abortion

The same *AMA JOURNAL* article had the following to say regarding abortions:

"Legally abortion has been defined as the 'expulsion of the foetus at so early a stage of uterogestation that it has not acquired the power of sustaining an independent life.' By statute each of the several states has, in substance, provided that the performance of an abortion without therapeutic justification is unlawful. Differences exist, as may be expected, in the language of the several statutes and in the manner of their implementation. For example, some statutes require that the initial determination of therapeutic necessity be supported by the advice of another physician. Other statutes require the advice of two other physicians, and some statutes do not refer to or require consultation. That such consultation is medically and medicolegally desirable, if not mandatory, of course, needs no elaboration. The physician is expected to be familiar with the language of the statute that is in force in his own jurisdiction, and he is legally obliged to observe it.

"The courts are not in accord on the question of whether recovery may be had for injury resulting from negligence in the performance of abortion contrary to law. The weight of authority is that a woman cannot recover damages in such a situation, because her consent to the illegal act should and does constitute a bar to recovery. There are, however, cases that have permitted recovery. The physician who contemplates the performance of an abortion for a therapeutic reason is well advised to obtain appropriate consent, to have consultation, and to maintain adequate records of the case."

Following are three sections of the Revised Code of Ohio relating to the subject of abortions:

"**Section 2901.16**—No person shall prescribe or administer a medicine, drug, or substance, or use an instrument or other means with intent to procure the miscarriage of a woman, unless such miscarriage is necessary to preserve her life, or is advised by two physicians to be necessary for that purpose.

"Whoever violates this section, if the woman either miscarries or dies in consequence thereof, shall be imprisoned not less than one nor more than seven years."

"**Section 2901.17**—In the trial of a person indicted for a violation of Section 2901.16 of the Revised Code, the woman whose miscarriage was procured may be called as a witness by the state. If, being so called, she testifies fully to the cause of such miscarriage, she shall not thereafter be prosecuted for her participation or complicity in such offense.

"On such trial the dying declaration of a woman, who died in consequence of the miscarriage or attempt to produce a miscarriage under investigation, as to the cause and circumstances of such miscarriage or attempt, is admissible."

"**Section 2905.32**—No person shall sell, give away, or keep for sale or gratuitous distribution a secret drug or nostrum purporting to be exclusively for the use of females, or for preventing conception, or for procuring abortion or miscarriage.

"Whoever violates this section shall be fined not more than one thousand dollars or imprisoned not more than six months, or both."

COMING MEETINGS

Ohio State Medical Association, 1959 Annual Meeting, April 21-24, Columbus.

American Medical Association, Clinical Session, December 2-5, Minneapolis, Minn.

American Association of Medical Assistants, Palmer House, Chicago, October 31-November 2.

Central Ohio Heart Association, Scientific Council Session, Columbus, November 5.

Columbus Academy of Medicine, Clinic Day, Columbus, November 1.

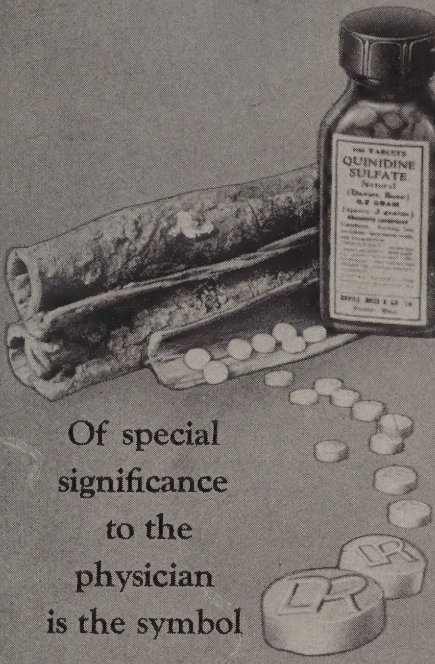
Mississippi Valley Trudeau Society, Dayton, October 17.

National Institute of Arthritis and Metabolic Diseases, Session on Rheumatic Diseases, Ohio State University Campus, Columbus, October 19.

Ohio Hospital Association, Institute on Infections, Columbus, October 15.

Sixth Councilor District, Postgraduate Day, October 22, Akron.

Veterans Administration, Series of Clinical Conferences, Cleveland, Wednesday Evenings.



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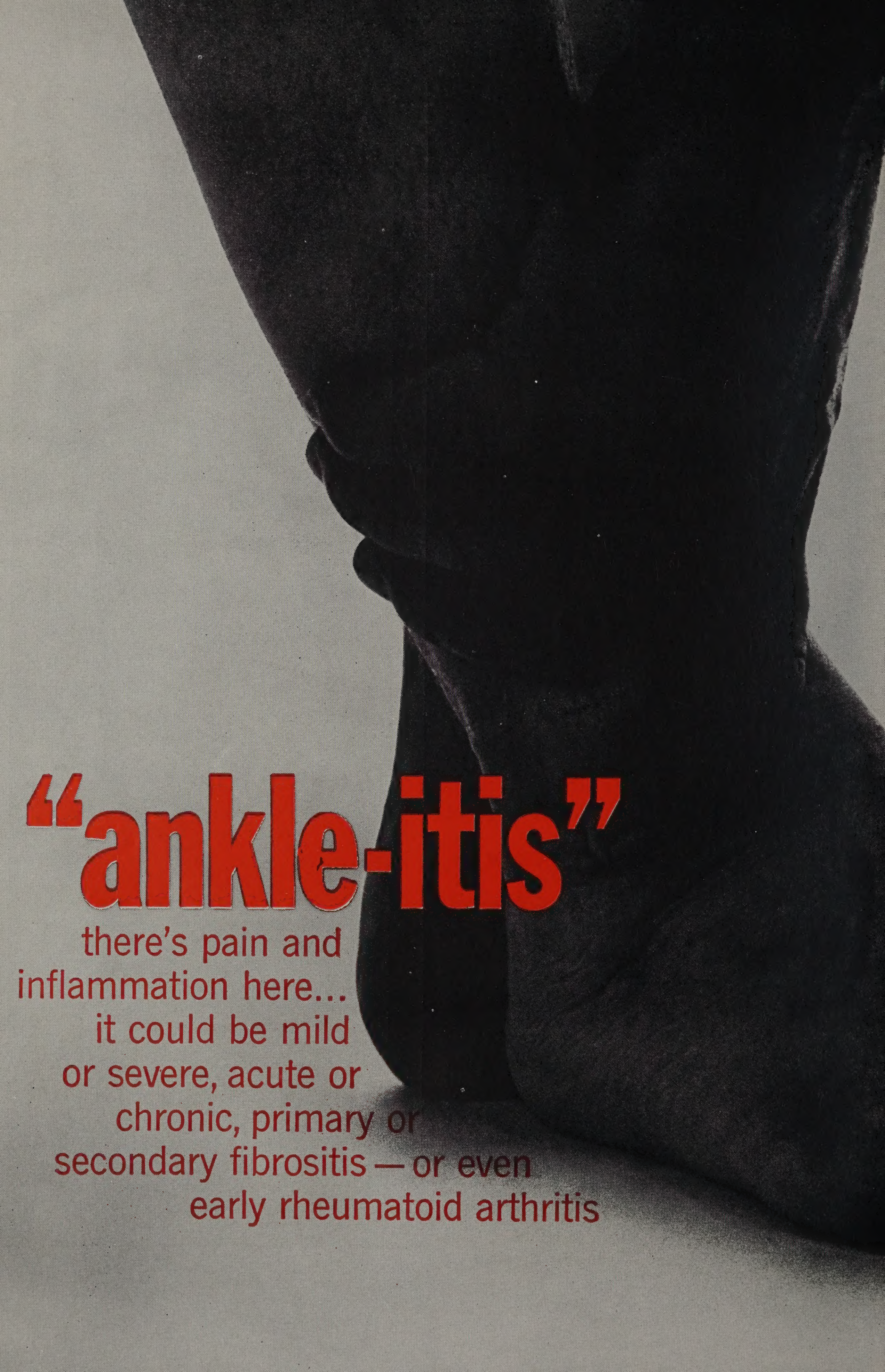
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it could be mild
or severe, acute or
chronic, primary or
secondary fibrositis — or even
early rheumatoid arthritis

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assured anti-inflammatory effect of low-dosage corticosteroid[1] . . . additive antirheumatic action of corticosteroid plus salicylate[2-5] brings rapid pain relief; aids restoration of function . . . wide range of application including the entire fibrositis syndrome as well as early or mild rheumatoid arthritis

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subacute or chronic conditions: Initially as above. When satisfactory control is obtained, gradually reduce the daily dosage to minimum effective maintenance level. For best results administer after meals and at bedtime.

precautions: Because SIGMAGEN contains prednisone, the same precautions and contraindications observed with this steroid apply also to the use of SIGMAGEN.

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Acetylsalicylic acid	325 mg.
Aluminum hydroxide	75 mg.
Ascorbic acid	20 mg.

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References: **1.** Spies, T. D., et al.: J.A.M.A. 159:645, 1955. **2.** Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. **3.** Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. **4.** Guerra, F.: Fed. Proc. 12:326, 1953. **5.** Busse, E. A.: Clin. Med. 2:1105, 1955. **6.** Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

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SG-J-618

Ohio's Narcotics Control Act . . .

Stringent Restrictions of the Law in Regard To Handling and Prescribing Narcotics Are Set Forth; Other Provisions of State Act Are Reviewed

OF interest to every physician in practice is the Ohio Narcotics Control Act. Recodification of this act in 1955 and tightening of many of its provisions brought it more nearly into conformity with Federal laws, and made penalties in Ohio equal or in some instances greater than those in surrounding states.

Abstracts of the Narcotics Law are presented herewith for the benefit of physicians who wish to review its provisions. Some parts of the law, not particularly pertinent to physicians, have been omitted from this report.

Penalties apply to minor or technical violations by physicians of the provisions regarding keeping of records, prescribing, dispensing, administering, etc. Drastic penalties are provided for anyone, including a physician, who participates in illicit traffic in narcotics, conspires with others to sell narcotics illegally, unlawfully sells, dispenses or administers narcotics to minors or induces minors to use or traffic in narcotics.

The act is designed to crack down hard on illicit dope peddlers. It imposes only enough restrictions on physicians to make it unpopular and unwise for them to become careless or negligent in handling narcotics.

Following are excerpts from the Narcotics Control Act of Ohio:

Excerpts from Act

Sec. 3719.01. As used in sections 3719.01 to 3719.22, inclusive, of the Revised Code:

(B) "Practitioner" means a person who is licensed in this state to prescribe, dispense, and administer narcotic drugs to a patient or to any animal.

(L) "Narcotic drugs" means coca leaves, opium, isonipecaine, amidone, isoamidone, ketobemidone, cannabis, and every substance not chemically distinguishable from them and every drug to which the federal laws relating to narcotic drugs may apply.

(M) "Isonipecaine" means any substance identified chemically as 1-methyl-4-phenyl-piperidine-4-carboxylic acid ethyl ester, or any salt thereof, by whatever trade name designated.

(N) "Amidone" means any substance identified chemically as 4-4-diphenyl-6-dimethylamino-heptanone-3, or any salt thereof, by whatever trade name designated.

(O) "Isoamidone" means any substance identified chemically as 4, 4-diphenyl-5-methyl-6-dimethylaminohexanone-3, or any salt thereof, by whatever trade name designated.

(P) "Keto-bemidone" means any substance identified chemically as 4-(3-hydroxyphenyl)-1-methyl-4-piperidyl ethyl ketone hydrochloride or any salt thereof, by whatever trade name designated.

(R) "Official written order" means an order written on a form provided for that purpose by the United States commissioner of narcotics, under any laws of the United States making provision therefor, if such order forms are authorized and required by federal law.

(S) "Dispense" means sell, distribute, leave with, give away, dispose of, or deliver.

(T) "Registry number" means the number assigned to each person registered under the federal narcotic laws.

(U) "Prescription" means a written or oral order for a narcotic drug for the use of a particular person or a particular animal given by a practitioner in accordance with the regulations promulgated by the United States commissioner of narcotics pursuant to the federal narcotic laws.

(W) "Nurse" means a person licensed to engage in the practice of nursing in this state.

Sales by Pharmacist

Sec. 3719.05. **(A) A pharmacist may dispense narcotic drugs to any person upon a written or oral prescription given by a practitioner. Each written prescription shall be properly executed, dated, and signed by the person prescribing on the day when issued and bearing the full name and address of the patient for whom, or of the owner of the animal for which, the narcotic drug is dispensed, and the full name, address, and registry number under the federal narcotic laws of the person prescribing. If the prescription be for an animal, it shall state the species of animal for which the drug is prescribed. The pharmacist filling the prescription shall write the date of filling and his own signature on the face of the prescription. The prescription shall be retained on file by the owner of the pharmacy in which it is filled for a period of two years, so as to be readily accessible for inspection by any public officer or employee engaged in the** enforcement of sections 3719.01 to 3719.22, inclusive, of the Revised Code. Each oral prescription shall be recorded by the pharmacist and such record shall show the name and address of the patient for whom, or of the owner of the animal for which, the narcotic drug is dispensed, the full name, address, and registry number under the federal narcotic laws of the practitioner prescribing, the name of the narcotic drug dispensed, the amount dispensed, and the date when dispensed. Such record shall be retained on file by the owner of the pharmacy in which it is filled for a period of two years. No prescription shall be refilled.

(C) A pharmacist may dispense, upon an official written order to a practitioner in quantities not exceeding one ounce at any one time, aqueous or oleaginous solutions of which the content of narcotic drugs does not exceed a proportion greater than twenty per cent of the complete solution, to be used for medical purposes.

Prescribing and Dispensing

Sec. 3719.06. (A) A practitioner licensed to prescribe, dispense, and administer narcotic drugs to a human being in the course of his professional practice may prescribe by a written or oral prescription, administer, or dispense narcotic drugs, or he may cause the same to be administered under his direction and supervision. Each written prescription shall be dated and signed by the practitioner prescribing on the day when issued and shall bear the full name and address of the person for whom the narcotic drug is prescribed and the full name, address, and registry number under the federal narcotic laws of the person prescribing.

(B) A practitioner licensed to prescribe, dispense, and administer narcotic drugs to an animal in the course of his professional practice and not for use by a human being, may prescribe, by a written or oral prescription, administer, and dispense narcotic drugs or he may cause them to be administered by an assistant or orderly under his direction and supervision. Each written prescription shall be dated and signed by the practitioner prescribing on the day when issued and shall bear the full name and address of the owner of the animal, the species of the animal for which the narcotic drug is prescribed and the full name, address, and registry number under the federal narcotic laws of the practitioner prescribing.

(C) Any person, who has obtained from a practitioner any narcotic drug for administration to a human being or an animal during the absence of such practitioner, shall return to such practitioner any unused portion of such drug,

(Continued on Page 1370)

Cook County
Graduate School of Medicine

INTENSIVE POSTGRADUATE COURSES

STARTING DATES — FALL, 1958

SURGERY—Surgical Technic, two weeks, Oct. 27, Nov. 10. Surgery of Colon & Rectum, one week, Oct. 27, December 1. Basic Principles in General Surgery, two weeks, Oct. 13. Gallbladder Surgery, three days, Nov. 3. Surgery of Hernia, three days, Nov. 6. General Surgery, two weeks, Nov. 10; one week, Oct. 27. Fractures & Traumatic Surgery, two weeks, Dec. 1. American Board Review Course, two weeks, Nov. 10. Blood Vessel Surgery, one week, Oct. 20.

GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, two weeks, Oct. 13. Vaginal Approach to Pelvic Surgery, one week, Nov. 17. General & Surgical Obstetrics, two weeks, Oct. 27.

MEDICINE—General Review Course, two weeks, Oct. 20. Electrocardiography, two-week basic course, Oct. 6. Gastroscopy & Gastroenterology, two weeks, Nov. 3.

DERMATOLOGY—Clinical & Didactic Course, two weeks, Nov. 3.

UROLOGY—Ten-Day Practical Course in Cystoscopy by appointment.

RADIOLOGY—Diagnostic X-Ray, two weeks, Dec. 1.

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FINNERTY, F. A., Buchholz, J. H. and Tuckman, J.: J.A.M.A. **166**:141, Jan. 11, 1958.

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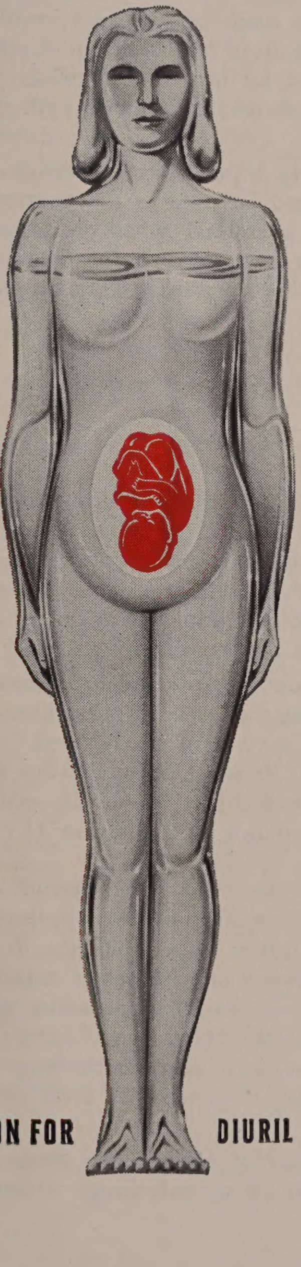

ANY INDICATION FOR DIURESIS IS AN INDICATION FOR DIURIL

when it is no longer required by such human being or animal.

Keeping of Records

Sec. 3719.07. (A) Every practitoner, or other person who is authorized to administer or use narcotic drugs, shall keep a record of all such drugs received by him, and a record of all such drugs administered, dispensed, or used by him otherwise than by prescription in accordance with the provisions of division (E) of this section. The keeping of a record of the quantity, character, and potency of solutions or other preparations purchased or made up by a practitioner or other person using small quantities of solutions or other preparations of narcotic drugs for local application, and of the dates when purchased or made up, without keeping a record of the amount of such solution or other preparation applied by him to individual patients shall be a sufficient compliance with this division.

No record need be kept of narcotic drugs administered, dispensed, or used in the treatment of any one person or animal, when the amount administered, dispensed, or used for that purpose does not exceed in any forty-eight consecutive hours:

(1) Two grains of opium;

(2) One-half of a grain of morphine or of any of its salts;

(3) Four grains of codeine or of any of its salts;

(4) One-third of a grain of dihydrocodeinone;

(5) A quantity of any other narcotic drug or any combination of narcotic drugs that does not exceed in pharmacologic potency any one of the drugs named above in the quantity stated.

(D) Every person who purchases for resale, or who dispenses narcotic drug preparations exempted by section 3719.15 of the Revised Code shall keep a record showing the quantities and kinds thereof received, dispensed, or disposed of otherwise, in accordance with division (E) of this section.

(E) Every practitioner or other person, except a pharmacist, manufacturer, or wholesaler, authorized to administer or use narcotic drugs shall when the keeping of a record is required by the federal narcotic laws or regulations promulgated by the United States commissioner of narcotics, keep a record of all narcotic drugs received, administered, dispensed, or used which shall contain:

(1) A description of all narcotic drugs received, the quantity of narcotic drugs received, the name and address of the person from whom received, and the date of receipt;

(2) The kind and quantity of narcotic drugs administered, dispensed, or used, the date of administering, dispensing, or using, the name and address of the person to whom, or for whose use, or the owner and species of the animal for which the narcotic drug was administered, dispensed, or used.

Every such record shall be kept for a period of two years and the date of the transaction recorded.

The keeping of a record required by or under the federal narcotic laws, containing substantially the same information as specified in this section, shall constitute compliance with this section.

Every person who purchases for resale or who sells narcotic drug preparations exempted by section 3719.15 of the Revised Code shall keep the record required by or under the federal narcotic law.

Licensing Agency To Be Informed

Sec. 3719.12. On the conviction of a manufacturer, wholesaler, practitioner, pharmacist, or nurse of the violation of sections 3719.01 to 3719.22, inclusive, of the Revised Code a copy of the judgment and sentence of the court or magistrate shall be sent by the clerk of the court, or by the magistrate, to the board or officer by whom such manufacturer, wholesaler, practitioner, pharmacist, or nurse has been licensed or registered to practice his profession or to carry on his business. Such board or officer shall have the power to revoke such license or registration.

Suspension of License

Sec. 3719.121. Any practitioner, nurse, pharmacist, manufacturer, or wholesaler, who is or shall become addicted to the use of narcotic drugs, shall have his license or registration suspended by the board under which he has been licensed or registered until such time as such practitioner, nurse, pharmacist, manufacturer, or wholesaler shall offer satisfactory proof to such board that he is no longer addicted to the use of narcotic drugs.

Inspections

Sec. 3719.13. Prescriptions, orders, and records, required by sections 3719.01 to 3719.22, inclusive, of the Revised Code, and stocks of narcotic drugs, shall be open for inspection only to federal, state, county and municipal officers, whose duty it is to enforce the laws of this state or of the United

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Improve appetite and energy
with ample amounts of vitamins—B_1, B_6, B_{12}.

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Each teaspoonful (5 cc.) contains:

l-Lysine HCl	300 mg.
Vitamin B_{12} Crystalline	25 mcgm.
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Ferric Pyrophosphate (Soluble)	250 mg.
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States relating to narcotic drugs. No officer having knowledge, by virtue of his office, of any such prescription, order, or record shall divulge such knowledge, except in connection with a prosecution or proceeding in court or before a licensing or registration board or officer, to which prosecution or proceeding the person to whom such prescriptions, orders or records relate is a party.

Exempt Preparations

Sec. 3719.15. Except as specifically provided in sections 3719.01 to 3719.22, inclusive, of the Revised Code such sections shall not apply to the following cases:

(A) Where a practitioner administers or dispenses; or where a pharmacist or owner of a pharmacy sells at retail any medicinal preparation that contains in one fluid ounce, or if a solid or semisolid preparation, in one avoirdupois ounce:

(1) Not more than two grains of opium;

(2) Not more than one quarter of a grain of morphine or of any of its salts;

(3) Not more than one grain of codeine or of any of its salts;

(4) Not more than one-sixth of a grain of dihydrocodeinone;

(5) Not more than one half of a grain of extract of cannabis nor more than one half of a grain of any more potent derivative or preparation of cannabis;

(B) Where a practitioner administers or dispenses; or where a pharmacist sells at retail liniments, ointments, and other preparations, that are susceptible of external use only and that contain narcotic drugs in such combination as prevent their being readily extracted from such liniments, ointments, or preparations, except that such sections shall apply to all liniments, ointments, and other preparations, that contain coca leaves in any quantity or combination.

The medicinal preparation, or the liniment, ointment, or other preparation susceptible of external use only, prescribed, administered, dispensed, or sold, shall contain, in addition to the narcotic drug in it, some drug or drugs conferring upon it medicinal qualities other than those possessed by the narcotic drug alone. Such preparation shall be prescribed, administered, compounded, dispensed, and sold in good faith as a medicine, and not for the purpose of evading such sections.

Limits to Any One Person

Sec. 3719.16. No person shall prescribe, administer, dispense, or sell, under the exemptions of section 3719.15 of the Revised Code to any one person, or for the use of any one person or animal, any preparation included within such section, when he knows, or can by reasonable diligence ascertain, that such prescribing, administering, dispensing, or selling will provide the person to whom or for whose use, or the owner of the animal for the use of which, such preparation is prescribed, administered, dispensed, or sold, within any forty-eight consecutive hours, with more than two grains of opium, or more than one half of a grain of morphine or any of its salts, or more than four grains of codeine or of any of its salts, or more than one third of a grain of dihydrocodeinone, or will provide such person or the owner of such animal, within forty-eight consecutive hours, with more than one preparation exempted by the provisions of section 3719.15 of the Revised Code.

False Statements

Sec. 3719.171. No person shall:

(A) Knowlingly make a false statement in any prescription, order, report, or record, required by sections 3719.01 to 3719.22, inclusive, of the Revised Code;

(B) Make or utter any false or forged prescription or official written order:

(C) Affix any false or forged label to a package or receptacle containing narcotic drugs.

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THE LATEST "TIMED DISINTEGRATION" CAPSULE

- BALANCED APPETITE DEPRESSANT
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D'Amphetamine Sulfate	7.5 mg.
Amobarbital	30.0 mg.
Vitamin B-1	1.0 mg.
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FERENCES: 1. Carlozzi, M.: Ant. Med. & Clin. Therapy 5:146 (Feb.) 1958. 2. Welch, H.; Wright, W. W., and Staffa, A. W.: Ant. Med. Clin. Therapy 5:52 (Jan.) 1958. 3. Marlow, A. A., and Bartlett, G. R.: Glucosamine and Leukemia. Proc. Soc. Exp. Biol. & Med. 84:41, 53. 4. Shalowitz, M.: Clin. Rev. 1:25 (April) 1958. 5. Nathan, L. A.: Arch. Pediat. 75:251 (June) 1958. 6. Cornbleet, T.; Chesrow, E., d Barsky, S.: Ant. Med. & Clin. Therapy 5:328 (May) 1958. 7. Stone, M. L.; Sedlis, A., Bamford, J., and Bradley, W.: Ant. Med. & lin. Therapy 5:322 (May) 1958. 8. Harris, H.: Clin. Rev. 1:15 (July) 1958.

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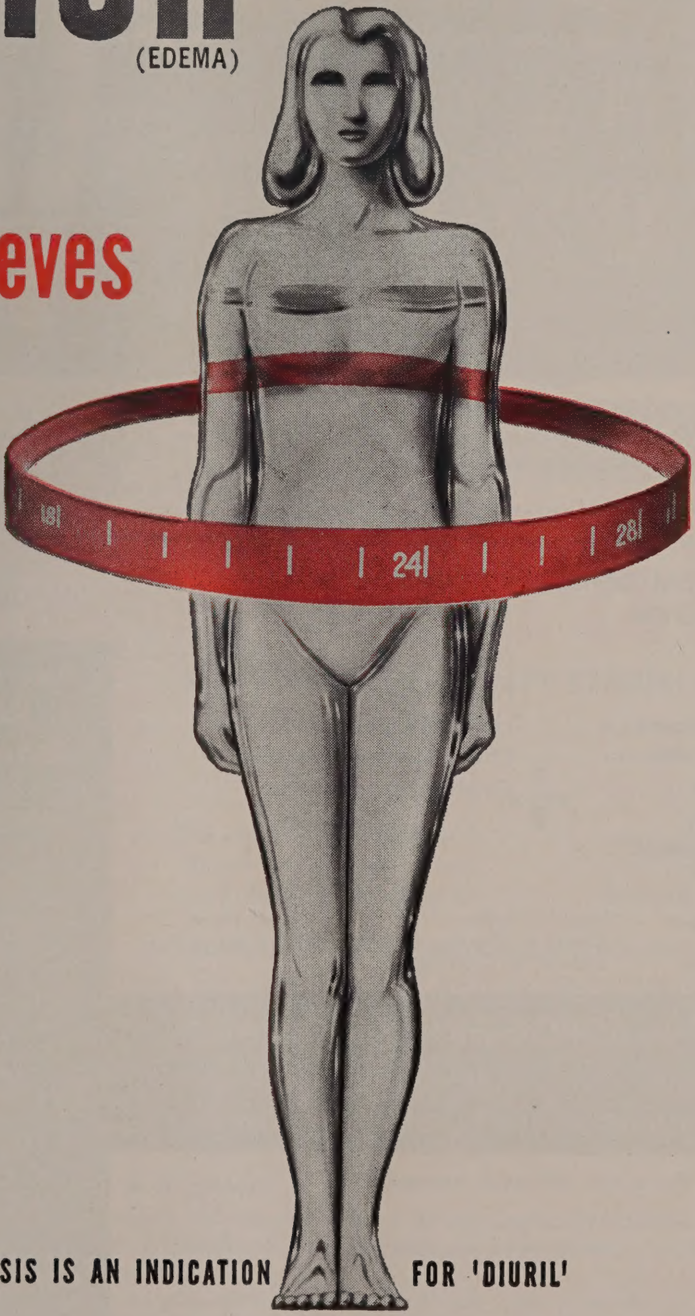

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1. Welsh, A. L., and Ede, M.: J.A.M.A. *166*:158, 1958.
2. Bleiberg, J.: J.M. Soc. New Jersey *53*:37, 1956.
3. Abrams, B. P., and Shaw, C.: Clin. Med. *3*:839, 1956.
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5. Clyman, S. G.: Postgrad. Med. *21*:309, 1957.

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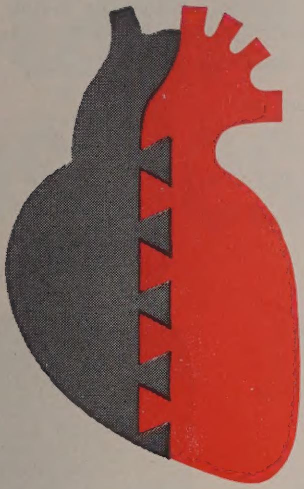

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1. *Friedlander, H. S.: The role of ataraxics in cardiology. Am. J. Card.* **1**:*395, March 1958.*
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[2] Baird, H. W., III: A comparison of Meprospan (sustained action meprobamate capsule) with other tranquilizing and relaxing agents in children. Submitted for publication, 1958.

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References: 1. Drugs of Choice 1958-1959, St. Louis, C. V. Mosby Company, 1958, p. 347.
2. Goldsmith, J. W.: Minnesota Med. *40*:99 (Feb.) 1957.

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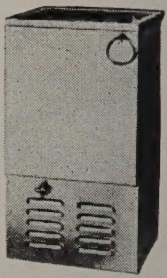

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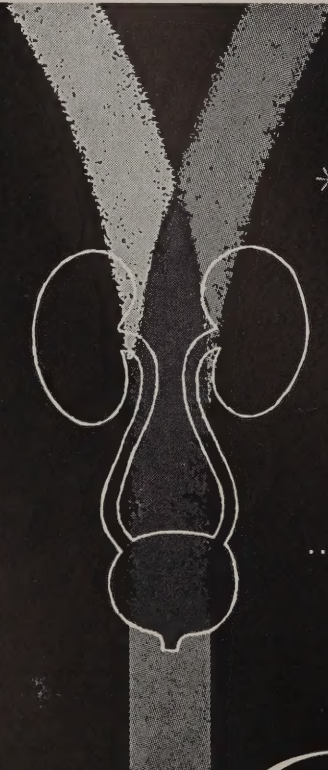

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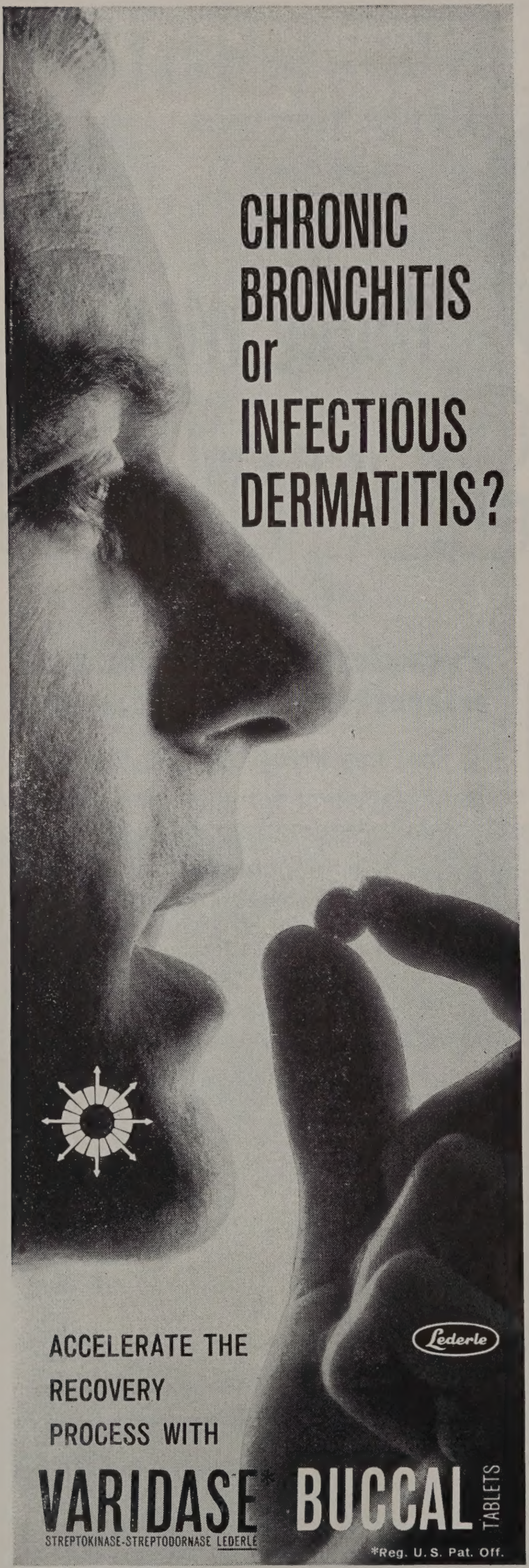
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REFERENCES: (1) Greenblatt, R. H., & Jungck, E. C.: *J.A.M.A.* 166:1461 (Mar. 22) 1958. (2) Hertz, Waite, J. H., & Thomas, L. B.: *Proc. Soc. Exper. Biol. & Med.* 91:418, 1956.

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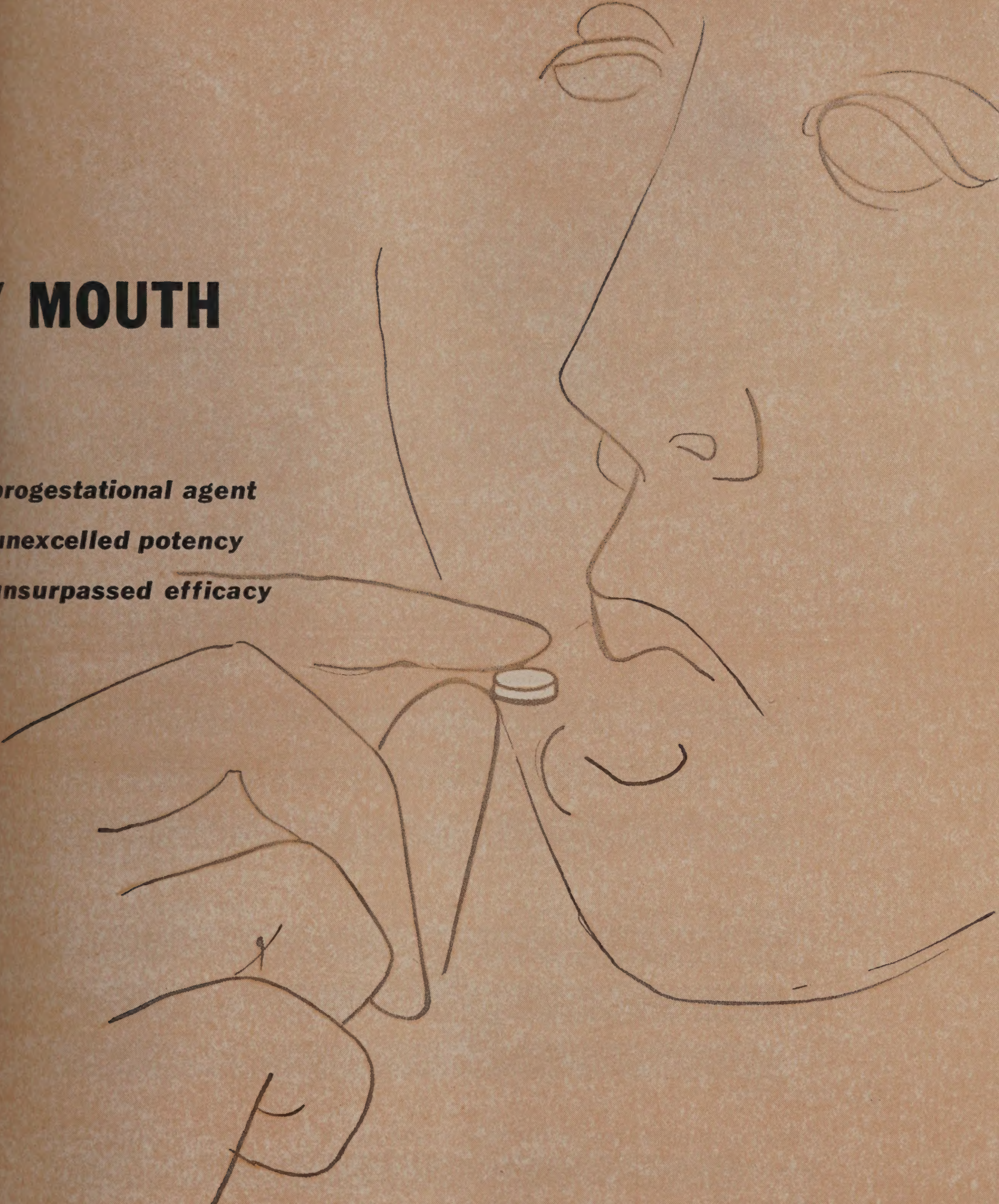

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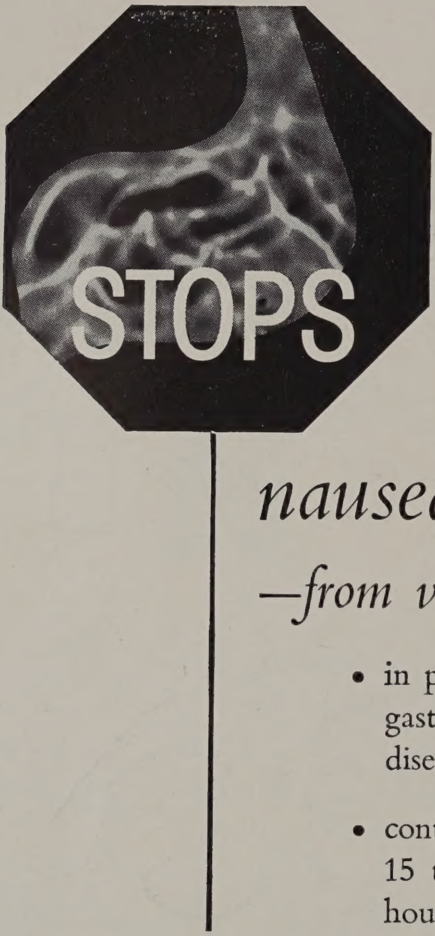

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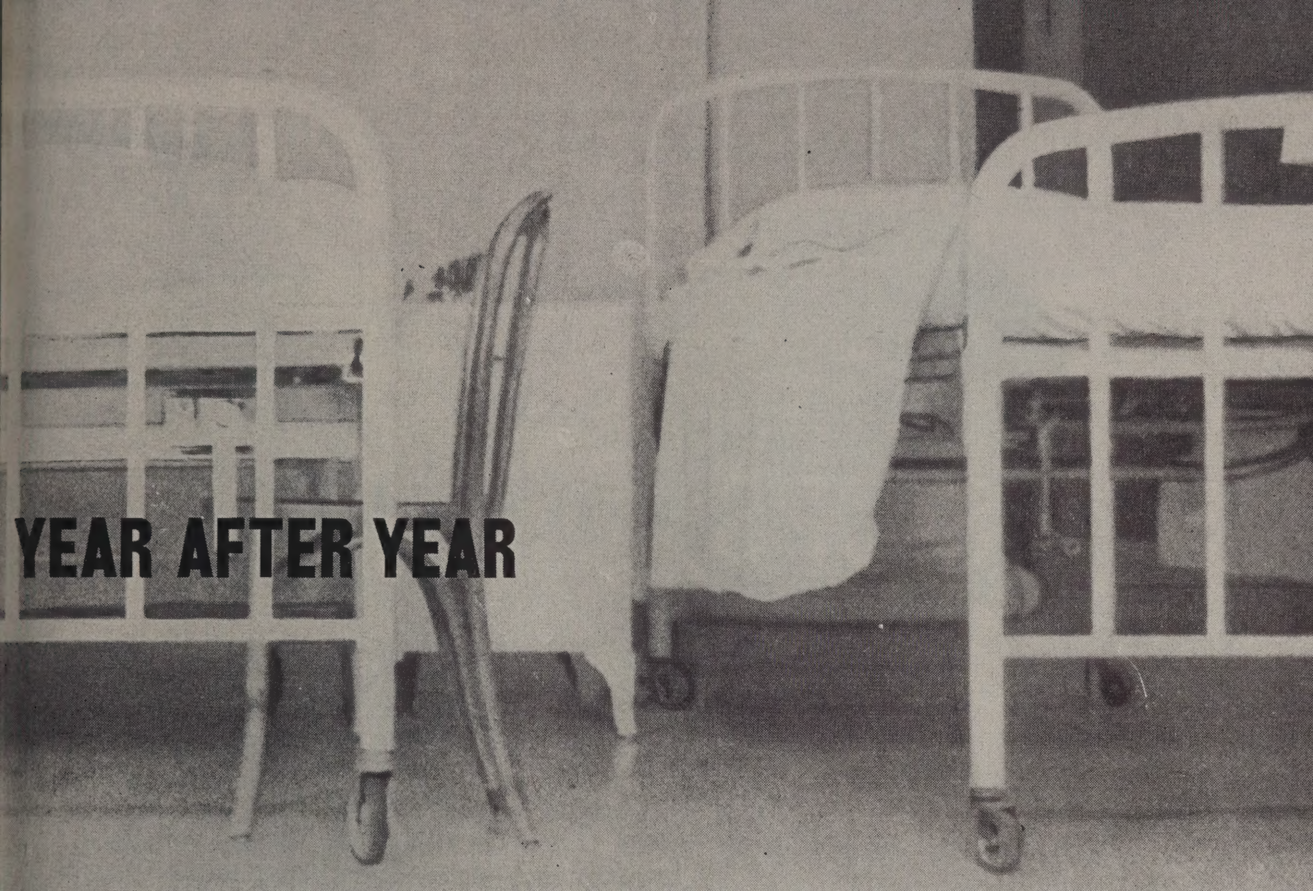

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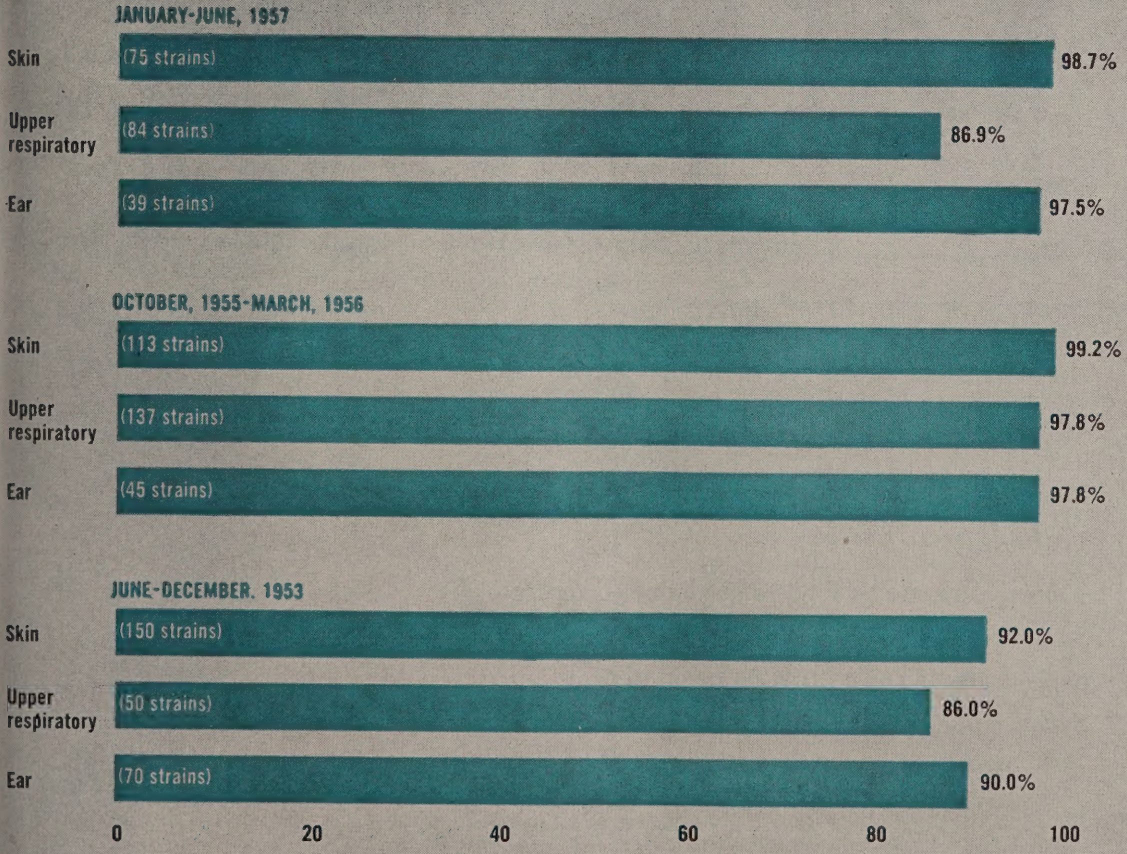

*Adapted from Royer.[1]

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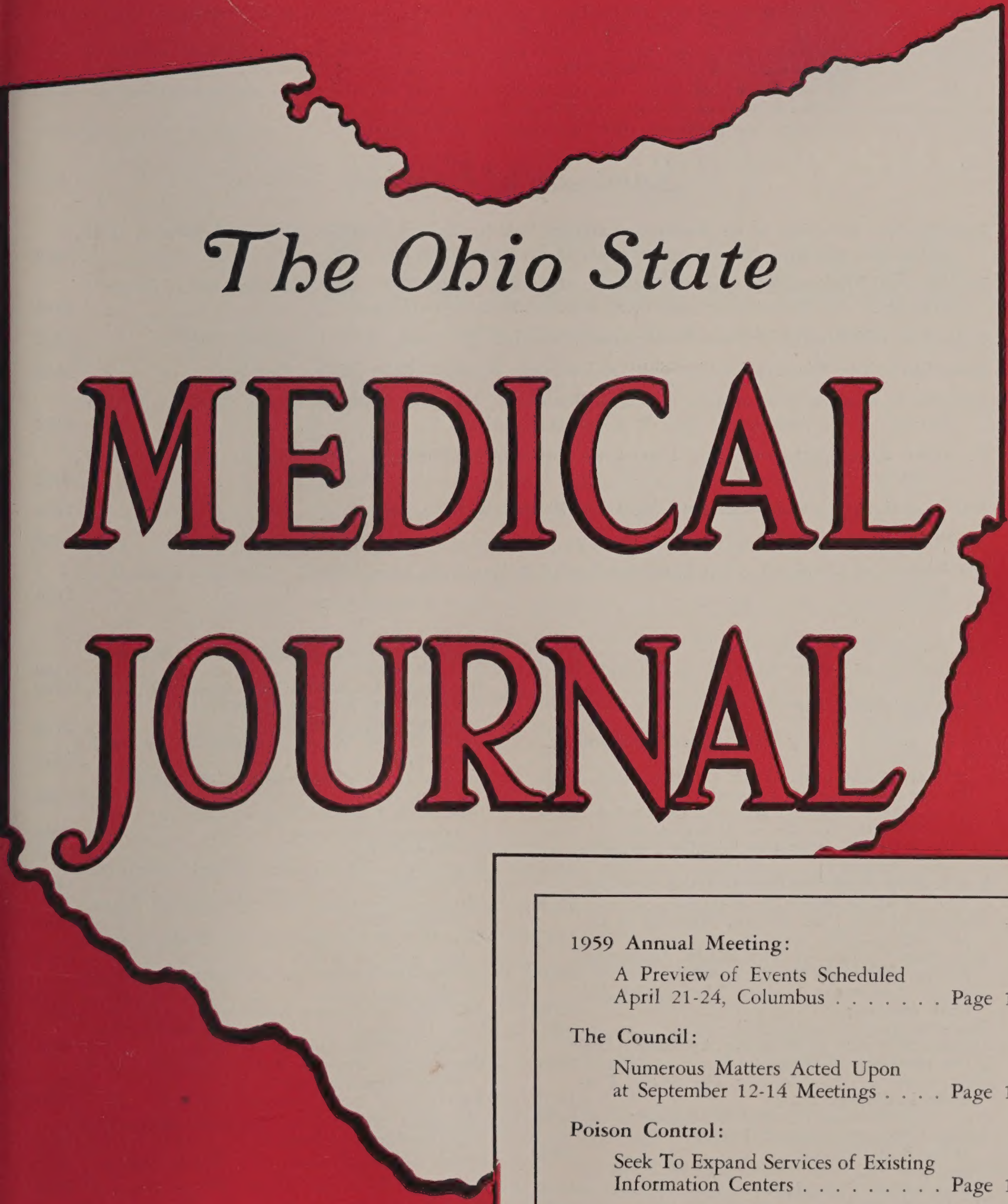

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(1) Hagedorn, A. B.: Proc. Staff Meet. Mayo Clin. 32:705 (Dec. 11) 1957.
(2) Best, W. R.; Louis, J., and Limarzi, L. R.: M. Clin. North America (Jan.) 1958, p. 3.

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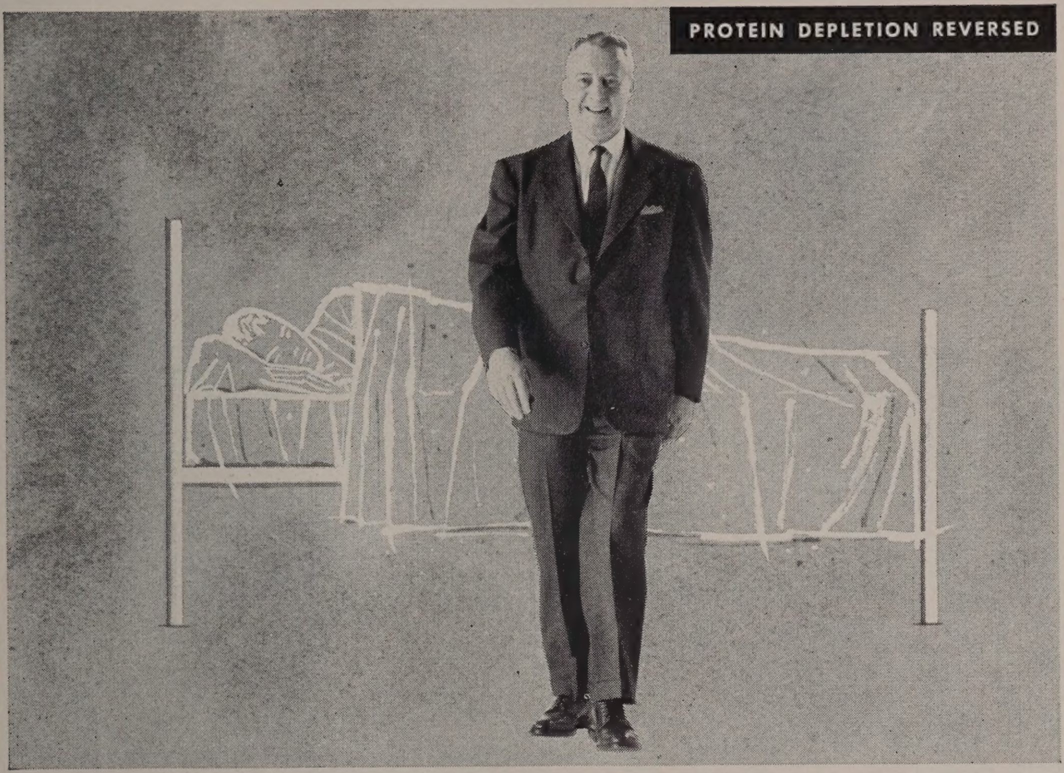

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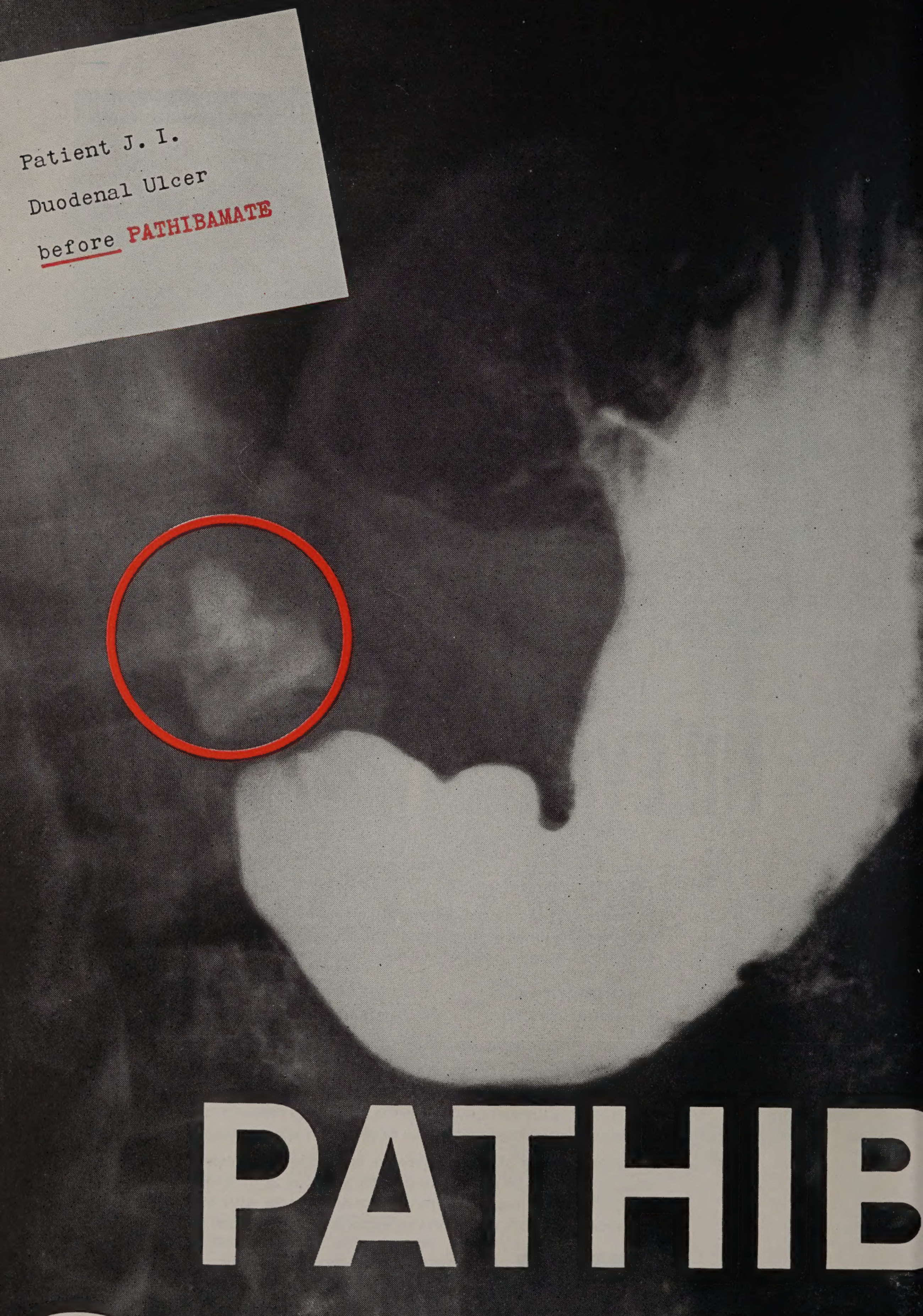

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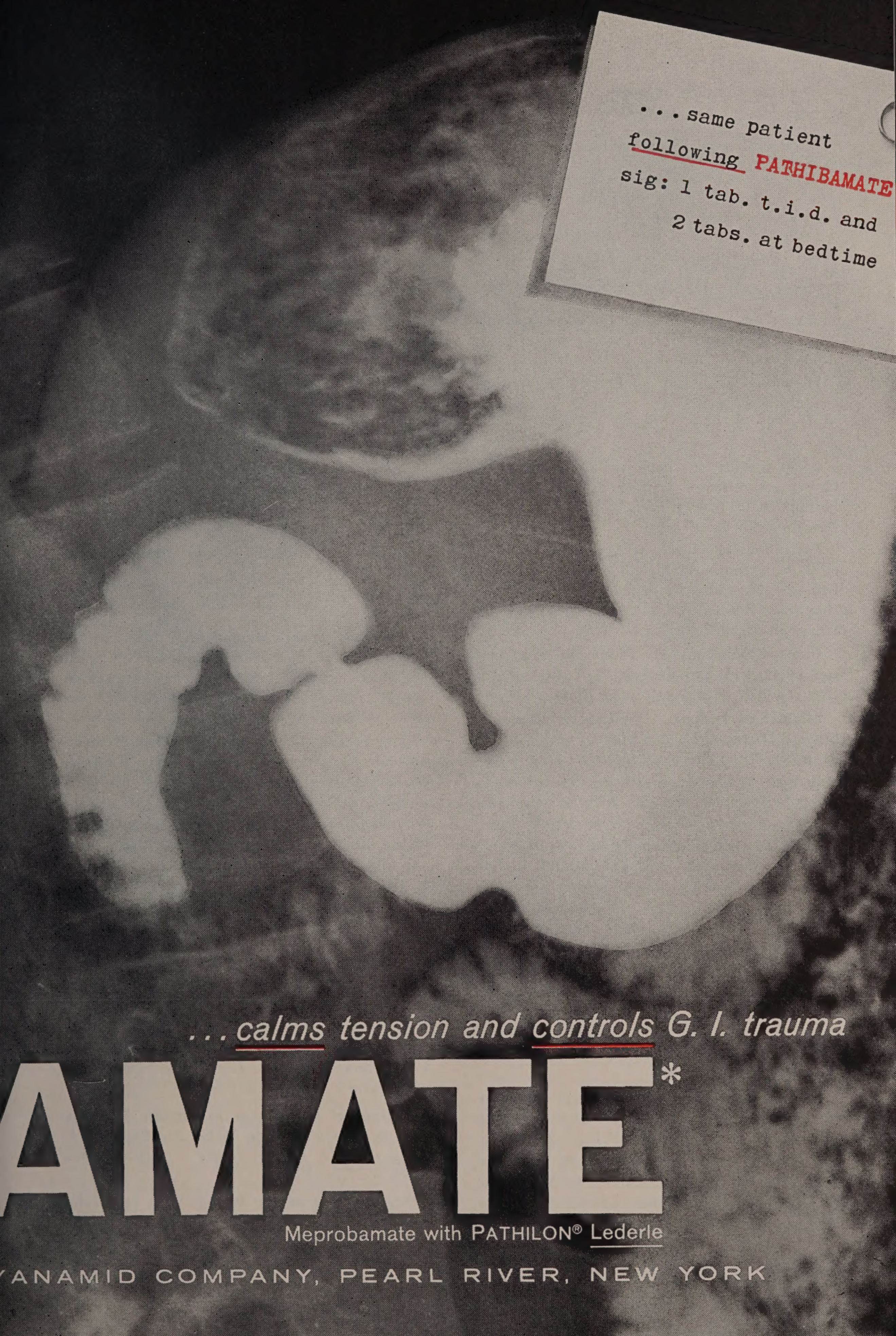

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The Physician's Bookshelf

(Books received from publishers. *The Journal* is not obligated to list herein every book received. It will try to list those which appear to be of greatest interest.)

* * *

Collected Papers of the Mayo Clinic and the Mayo Foundation; 1956, by Richard M. Hewitt, M.D., and staff. ($12.50, *W. B. Saunders Company, Philadelphia 5, Pa.)*

Autonomic Imbalance and the Hypothalamus, by Ernst Gellhorn, M. D. ($8.50, *University of Minnesota Press, Minneapolis 14, Minn.)*

Hormonal Regulation of Energy Metabolism, compiled and edited by Laurance W. Kinsell, M. D. ($5.25, *C. C. Thomas Publisher, Springfield, Ill.)*

From Sterility to Fertility: A Guide to the Causes and Cure of Childlessness, by Elliot E. Philipp, M. D. ($4.75, *Philosophical Library, Inc., New York 16, N. Y.)*

Psychological Aspects of Ageing: Proceedings of the Conference on Planning Research, held at Bethesda, Maryland, by John E. Anderson. (2.00, *American Psychological Association, 1333 6th Street, N. W., Washington, D. C.)*

Induced Delusions, The Psychopathy of Freudism, by Coyt H. Campbell, M. D. ($4.00, *Regent House, 4707 Broadway, Chicago, Illinois.)*

Manual of Pediatric Physical Diagnosis, by Lewis A. Barness, M. D. ($4.00, *The Year Book Publishers, Inc., Chicago, Illinois.)*

Bedside Diagnosis, by Charles Seward, M. D. ($5.50, 4th edition, *William & Wilkins Company, Baltimore 2, Maryland.)*

Artificial Insemination in the Human, by A. M. C. M. Schellan, M. D. ($14.00, *Elsevier Press, Inc., Bank of the Southwest Building, Houston 2, Texas.)*

Book of Health: The Official AMA Book of Health, by W. W. Bauer, M. D. (35¢, A Dell First Edition, compiled from recent articles in **Today's Health,** *Dell Publishing Company, Inc., New York 16, N. Y.)*

The Chronically Ill, by Joseph Fox, Ph. D. ($3.95, *Philosophical Library, Inc., New York 16, New York.)*

Miracle Drugs in the New Age of Medicine, by Fred Reinfeld. ($3.95, *Sterling Publishing Company, New York 10, N. Y.)*

Human Blood Coagulation and Its Disorders, by Rosemary Biggs, M. D., and R. G. Macfarlane, M. D. ($8.50, 2nd edition, *Charles C. Thomas Publisher, Springfield, Illinois.)*

Orthopedics for the General Practitioner, by William E. Kenney, M. D., and Carroll B. Larson, M. D. ($11.50, 180 illustrations, *The C. V. Mosby Company, St. Louis 3, Missouri.)*

Management of Complications in Eye Surgery, by R. M. Fasanella, M. D., contributed to by 20 authorities. ($16.00, *W. B. Saunders Company, Philadelphia 5, Pa.)*

The Premature Baby, by V. Mary Crosse. ($5.00, *Little, Brown and Company, Boston 6, Massachusetts.)*

Introduction to Anesthesia, by Robert D. Dripps, M. D., James E. Eckenhoff, M. D., and Leroy D. Vandam, M. D. ($4.75, *W. B. Saunders Company, Philadelphia 5, Pa.)*

Dangerous Properties of Industrial Materials, by N. Irving Sax, assisted by five other authorities. ($22.50, *Reinhold Publishing Company, New York 22, N. Y.)*

Simplified Diet Manual, by the Nutrition Service of the Iowa State Department of Health in cooperation with the Iowa Dietetic Association. ($1.95, *Iowa State College Press, State Department of Health, Ames, Iowa.)*

The Impact of the Antibiotics on Medicine and Society, (Monograph II), by Iago Galdston, M. D. ($5.00, *International Universities Press, New York, New York.)*

Adventures in Medical Education, by G. Canby Robinson, M. D. ($5.00, *Harvard University Press, Cambridge 38, Mass.)*

Body Water in Man, by Maurice B. Strauss, M. D. ($7.00, *Little, Brown and Company, Boston 6, Mass.)*

Studies in Human Ecology, A Series of Lectures given at the Anthropological Society in Washington, *(Pan American Union of Washington D. C.)*

The Biology of Ageing, by W. P. Yappe and G. H. Bowme. ($4.25, *Hafner Publishing Company, New York 3, New York.)*

Peripheral Circulation in Health and Disease, by Walter Redisch, M. D., and Francisco F. Tangco, M. D. ($7.75, *Grune & Stratton, New York 16, New York.)*

Management of the Patient with Headache, by Perry S. MacNeal, Bernard J. Alpers, M. D., and William R. O'Brien. ($3.50, *Lea & Febiger, Philadelphia 6, Pa.)*

Prescription for Survival, by Brock Chisholm. ($2.50, *Columbia University Press, New York 27, New York.)*

Chronic Illness in a Large City, by the Commission on Chronic Illness. ($8.00, *Harvard University Press, Cambridge 38, Mass.)*

Doctors in the Air, by Wing Commander Robert Maycock. ($3.75, *Thomas Nelson & Sons, New York 17, New York.)*

The Function of the Ureter and Renal Pelvis, by Frederik Kiil, M. D. ($7.50, *W. B. Saunders Company, Philadelphia 5, Pa.)*

Symposium on Diseases and Surgery of the Lens, by George M. Haik, M. D. ($10.50, *The C. V. Mosby Company, St. Louis 3, Missouri.)*

The Electrocardiogram, by Louis H. Sigler, M. D. ($8.75, second edition, *Grune & Stratton, New York 16, N. Y.*

Hormones in Blood; Ciba Foundation Colloquia on Endocrinology: Volume XI, by G. E. W. Wolstenholme and Elaine C. P. Millar. ($9.00, *Little, Brown and Company, Boston 6, Massachusetts.)*

The Principles and Practice of Diathermy, by Bryan O. Scott, D. Phys. Med. ($5.00, *Charles C. Thomas Publisher, Springfield, Illinois.)*

Bone Diseases in Medical Practice, by I. Snapper. ($15.00, *Grune & Stratton, Inc., New York 16, New York.)*

Clinical Orthopaedics, by Anthony F. De Palma, M. D., with the assistance of associate editors. ($7.50, Volume 10, *J. B. Lippincott Company, Philadelphia 5, Pa.)*

A Mental Health Handbook, by Ian Skottowe, M. D. ($5.00, *Williams & Wilkins Company, Baltimore 2, Maryland.)*

An Introduction to Dermatology, by G. H. Percival, M. D. ($9.00, *Williams and Wilkins, Baltimore 2, Maryland.)*

Cortisone Therapy: Mainly applied to the rheumatic diseases, by J. H. H. Glyn, M. D. ($10.00 *Philosophical Library, Inc., New York 16, New York.)*

The Infantile Cerebral Palsies, by Eirene Collis, W. R. F. Collis, William Dunham, L. T. Hilliard and David Lawson. ($3.00, *C. C. Thomas Publisher, Springfield, Illinois.)*

The Story of Peptic Ulcer: Dawn for Depressed and Disappointed Dyspeptics, by Richard D. Tonkin, M. D. ($2.25, *W. B. Saunders Company, Philadelphia 5, Pa.)*

Deafness, Mutism and Mental Deficiency in Children, by Louis Minski, M. D. ($3.75, *Philosophical Library, New York 16, New York.)*

Neomycin: Its Nature and Practical Application, by Selman A. Waksman. ($5.00, published for the Institute of Microbiology, Rutgers University, by *Williams & Wilkins Company, Baltimore 2, Maryland.)*

Textbook of Medical Treatment, by D. M. Dunlop, M. D., Sir Stanley Davidson, M. D., and S. Alstead, M. D. ($11.00, 7th edition, U. S. Distributors, *Williams & Wilkins Co., Baltimore 2, Maryland.)*

The Development and Disorders of Speech in Childhood, by Muriel E. Morley, F.C.S.T., foreword by Professor Donald Court, M. D. ($9.00, *E. & S. Livingstone, Ltd. of Edinburgh;* U. S. distributors: *Williams & Wilkins Company, Baltimore 2, Maryland.)*

Aids to Materia Medica and Therapeutics, by J. W. Hadgraft. ($3.25, 5th edition, *Bailliere, Tindall & Cox, London;* U. S. distributors, *Williams & Wilkins Company, Baltimore 2, Maryland.)*

May's Manual of the Diseases of the Eye, revised by Charles A. Perera, M. D. ($6.00, 22nd edition, *Williams & Wilkins Company, Baltimore 2, Maryland.)*

Arthritis Can Be Cured, by Bernhard Aschner, M. D. ($3.95, *Julian Press, 80 E. 11th St., New York 3, New York)*

Hemophilia and Hemophilioid Diseases, A Symposium arranged by the National Hemophilia Foundation, by Kenneth N. Brinkhous, M. D. ($7.50, *University of North Carolina Press, Chapel Hill, North Carolina.)*

Hepatitis Frontiers, by Frank W. Hartman, M. D., and his associates at the Henry Ford Hospital. ($12.50, *Little, Brown and Company, Boston 6, Mass.)*

Heart Sounds, Cardiac Pulsations, and Coronary Disease, by William Dock, M. D. ($2.50, *University of Kansas Press, Lawrence, Kansas.)*

Psychosomatic Ophthalmology, by T. F. Schlaegel, Jr., M. D. ($11.00, *Williams & Wilkins Company, Baltimore 2, Maryland.)*

Chronic Schizophrenia, by Thomas Freeman, John L. Cameron and Andrew McGhie. ($4.00, *International Universities Press, New York 11, New York.)*

Handbook of Treatment of Acute Poisoning, by E. H. Bensley, M. D., and G. E. Joron, M. D. ($4.00, Second edition, *E. & S. Livingstone LTD,* distributed by *Williams & Wilkins Company, Baltimore 2, Maryland.)*

Investigator

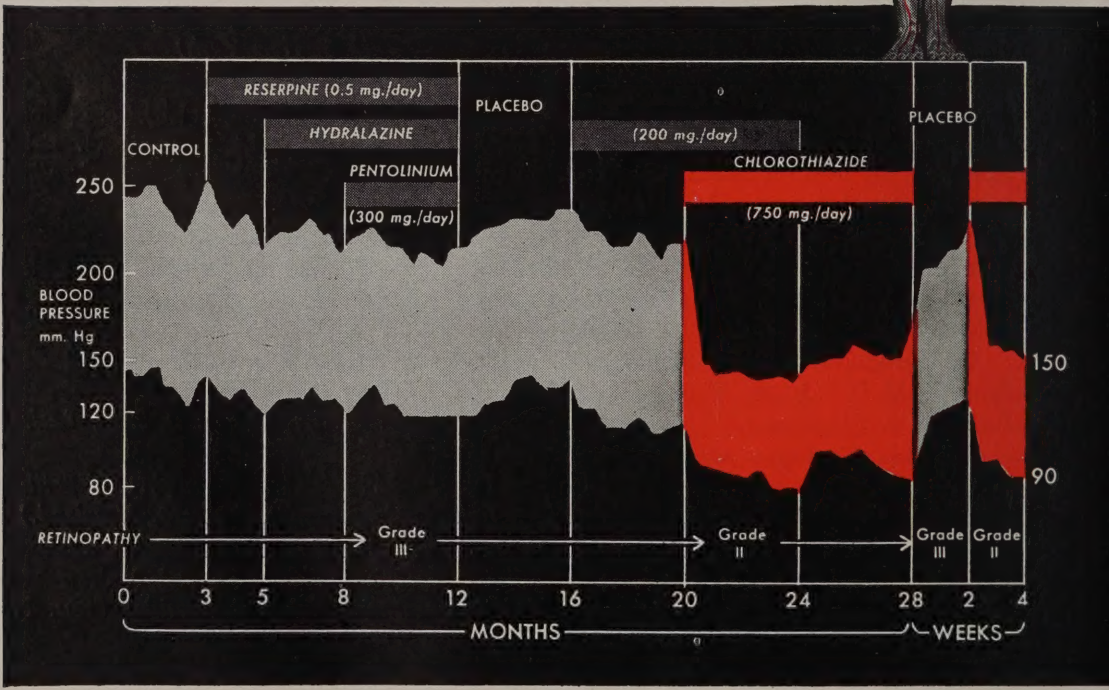
after investigator reports

Wilkins, R. W.: New England J. Med. 257:1026, Nov. 21, 1957.

"Chlorothiazide added to other antihypertensive drugs reduced the blood pressure in 19 of 23 hypertensive patients." "All of 11 hypertension subjects in whom splanchnicectomy had been performed had a striking blood pressure response to oral administration of chlorothiazide." ". . . it is not hypotensive in normotensive patients with congestive heart failure, in whom it is markedly diuretic; it is hypotensive in both compensated and decompensated hypertensive patients (in the former without congestive heart failure, it is not markedly diuretic, whereas in the latter in congestive heart failure, it is markedly diuretic). . . ."

Freis, E. D., Wanko, A., Wilson, I. H. and Parrish, A. E.: J.A.M.A. 166:137, Jan. 11, 1958.

"Chlorothiazide (maintenance dose, 0.5 Gm. twice daily) added to the regimen of 73 ambulatory hypertensive patients who were receiving other antihypertensive drugs as well caused an additional reduction [16%] of blood pressure." "The advantages of chlorothiazide were (1) significant antihypertensive effect in a high percentage of patients, particularly when combined with other agents, (2) absence of significant side effects or toxicity in the dosages used, (3) absence of tolerance (at least thus far), and (4) effectiveness with simple 'rule of thumb' oral dosage schedules."



In "Chlorothiazide: A New Type of Drug for the Treatment of Arterial Hypertension," Hollander, W. and Wilkins, R. W.: Boston Med. Quart. 8: 1, September, 1957.

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You and Your Public . . .

Motivational Researcher Lists Five Keys To Doctor-Patient Relationship

WHY do women buy more in supermarkets? What urge makes motorists want to speed past red automobiles? What type of candidate attracts voters?

The rapidly developing field of motivational research concerns itself with the answers to many questions such as these. It all boils down to "What makes John Doe Tick?" The motivation men are coming up with some surprising answers —and that's why doctors may find it is of interest when a motivation expert offers some keys to well-adjusted physician-patient relationship.

In this instance, Ernest Dichter, Ph. D., president of the Institute for Motivational Research, New York City, is the expert. He has guided motivation studies concerned with practical steps the medical profession can take to improve relationships. He offers for physicians the following five keys, which are well worth studying:

1. **Relax and learn to accept yourself.** The medical profession can do much to help the doctor resolve his own conflicts about his role. Through lectures and pamphlets the doctor can be made to understand that he is, after all, a person with material aspirations and needs as well as with ideals.

2. **Recognize the patient's right to information.** People are more sophisticated today than they once were, and they ask a great many more questions. They have read medical articles, they recognize some of the terminology, and they are unwilling to accept the unquestionable authority of the doctor. The doctor who treats his patients as if they are intelligent, aware people with a perfect right to understand the diagnosis and the treatment prescribed will find his patients responding with acceptance and with loyalty.

3. **Establish a continuous relationship.** In many areas doctors have begun to recognize the need for a continuous relationship not simply treatment when the patient is ill, but regular examinations to maintain good health. This is a sensible practice from a physical point of view and is psychologically correct as well, since it is an indication on the part of the doctor of his constant interest in his patients' welfare. A simple reminder that it is time for a check-up should be a part of every doctor's office procedure.

4. **Meet the fee question honestly.** Remember that patients resent fees which are tied to the saving of a life or the restoration of their health. To them this approach smacks of "blackmail." Patients also resent being billed on the basis of whatever "the traffic will bear." They want standard fees which are the same for everyone. They accept the doctor's need to make a living. They do not, however, accept the same increased costs for health and medical care that they accept for housing, for clothing, for food, for entertainment. They expect and get more from their doctor in terms of medical care, but they still resent increased costs. It is here that a general educational program is needed, and the medical profession could do much to show the public why increased costs for medical care are necessary, and actually how slight they have been compared to other increases.

5. **Recognize your community role.** Despite the changes which have occurred in medicine, the role of the doctor in the community is still a leading one. The doctor is a figure of importance. People consider him a community leader. They tend to judge him by his degree of interest in his community and also by such symbols of status as the kind of car he drives, the kind of home he lives in, etc. The doctor must decide for himself the kind of public image of himself he wishes to create. To create the proper image in terms of his practice and his community, he must recognize that he is a public figure, especially in a small community; and he must also recognize the standards and the needs of his patients.

This list of practical guides can be greatly enlarged, and can prove immensely helpful to the future of the medical profession if doctors can consider their role a segment of a much larger frame of reference, that of American democracy. Within this larger framework questions of authority versus equality and partnership become clear and understandable. These guides are steps in the growth from immaturity to maturity. More mature doctors will produce more mature patients, and both, of course, contribute to a greater maturity in every area of American life.

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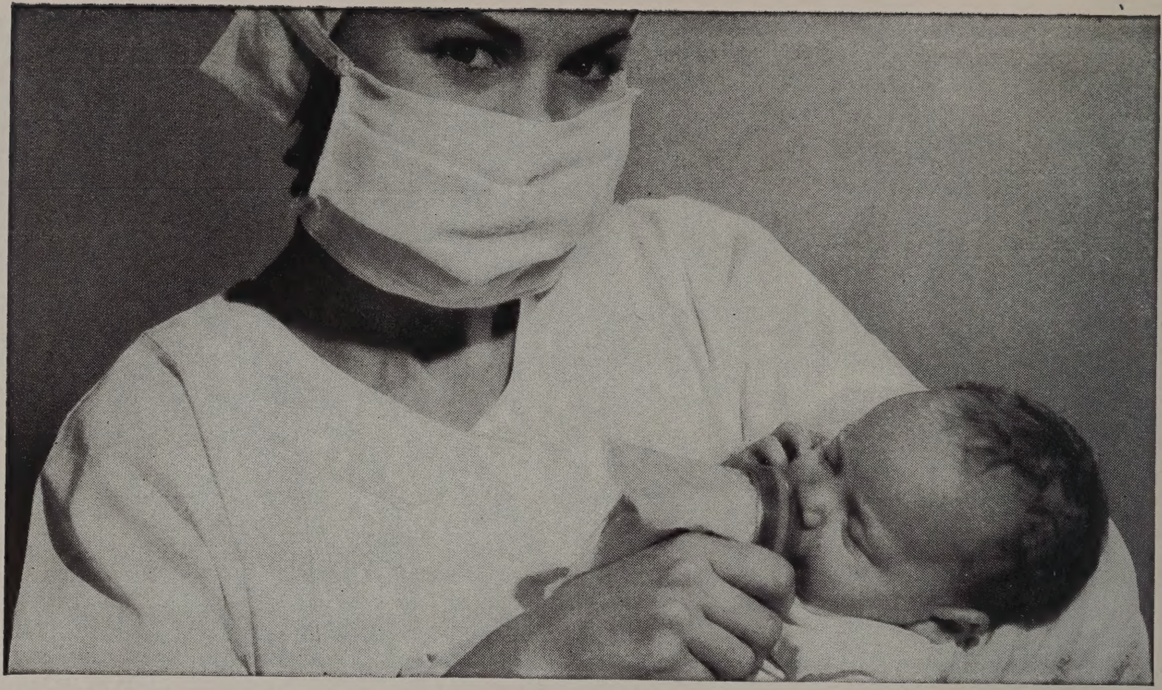

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The young infant may balk at new food or procedure. The older infant, devoted to his bottle, may resent weaning—it takes a certain readiness for weaning to make the change agreeable. Later, the infant may become somewhat independent and arbitrary—what he enjoyed yesterday he rejects today.

WHOLE MILK FORMULAS

Age Months	Whole Milk Fluid Oz.	Water Oz.	Karo Syrup Tbsp.	Each Feeding Oz.	Number of Feedings in 24 Hours	Total Calories
Birth	10	10	2	3	6	320
1	12	13	3	4	6	532
2	15	13	3	4½	6	480
3	17	9	3	5	5	520
4	20	11	3½	6	5	610
5	23	11	4	6½	5	700
6	26	10	4	7	5	760
7	28	11	3	7½	5	740
8	30	11	2½	8	5	750
10	32	9	2	8	5	760
12	32	9	0	8	5	640

EVAPORATED MILK FORMULAS

Age Months	Evaporated Milk Fluid Oz.	Water Oz.	Karo Syrup Tbsp.	Each Feeding Oz.	Number of Feedings in 24 Hours	Total Calories
Birth	6	12	2	3	6	380
1	8	16	3	4	6	532
2	9	14	3	4½	5	576
3	10	15	3½	5	5	650
4	12	18	4	6	5	768
5	12	21	4	6½	5	768
6	13	22	4	7	5	812
7	14	21	3	7	5	796
8	15	20	2	7	5	780
10	16	16	1	8	4	764
12	16	16	0	8	4	704

When a feeding problem is in the making, sensible decorum will solve it. Nature invites infant feeding cooperation through hunger. If hunger is appeased on demand rather than by clock there will be fewer problems—the baby is the best judge of when he wants food and how much.

Feeding must be adapted to the infant individually to make it a pleasurable experience. This is the current objective in successful infant feeding formulated for normal infants in the charts below:

ADVANTAGES OF KARO® SYRUP IN INFANT FEEDING

Composition: Karo Syrup is a superior dextrin-maltose-dextrose mixture because the dextrins are nonfermentable and the maltose is rapidly transformed into dextrose which requires no digestion.

Concentration: Volume for volume Karo Syrup furnishes twice as many calories as similar milk modifiers in powdered form.

Purity: Karo Syrup is processed at sterilizing temperatures, sealed for complete hygienic protection and devoid of pathogenic organisms.

Low Cost: Karo Syrup costs 1/5 as much as expensive milk modifiers and is available at all food stores.

Free to Physicians—Book of Infant Feeding Formulas with convenient schedule pads. Write: Karo Infant Feeding Guide, Box 280, New York 46, N. Y.

CORN PRODUCTS REFINING COMPANY

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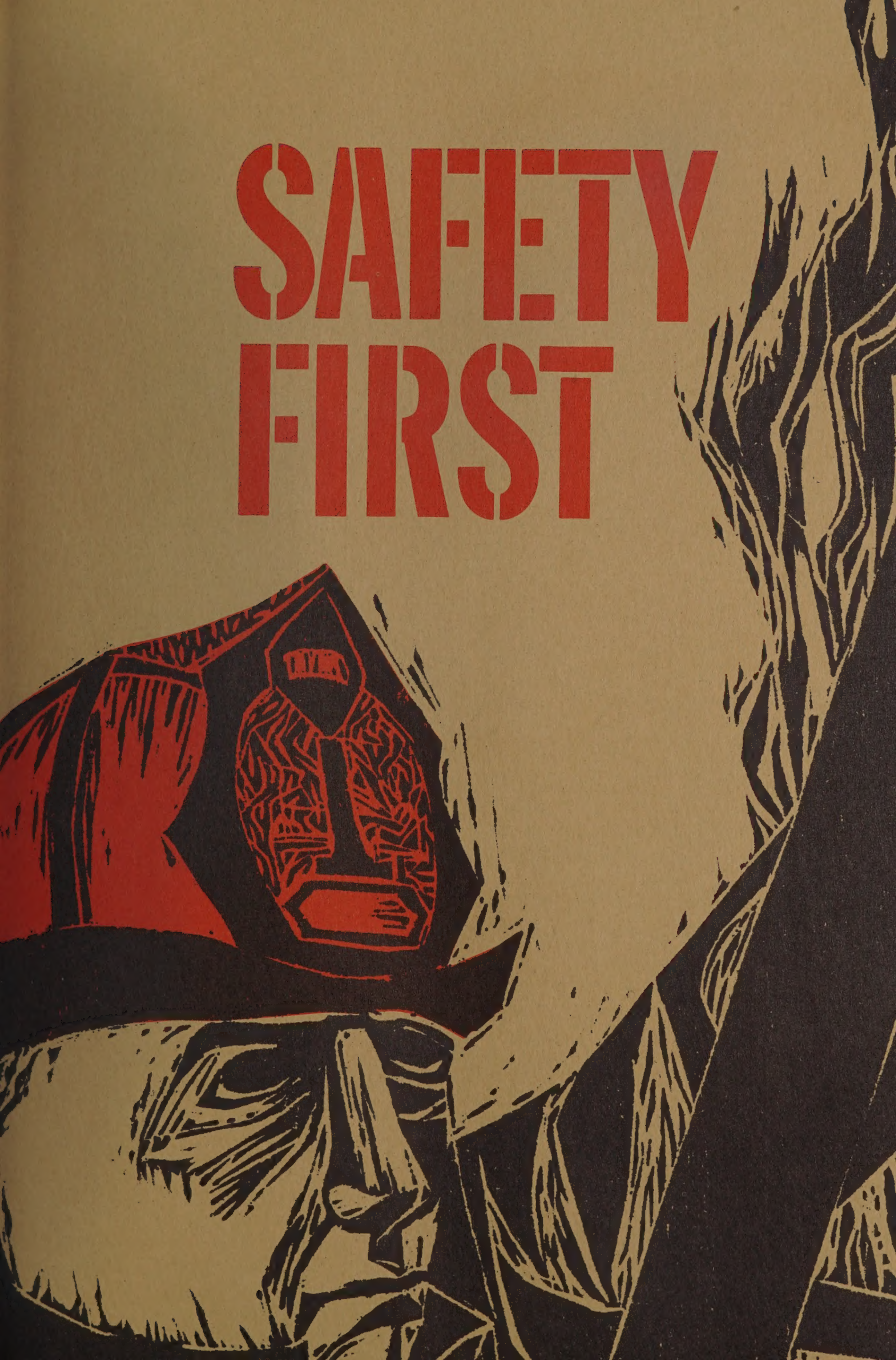

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STEARATE (ERYTHROMYCIN STEARATE, ABBOTT)

AFTER SIX YEARS, A SAFETY RECORD UNMATCHED IN SYSTEMIC ANTIBIOTIC THERAPY—PLUS REMARKABLE EFFECTIVENESS AGAINST THE COCCI

Actually, after all this time, there has not been a single, serious reaction to ERYTHROCIN. Also, the problem of resistance has remained unusually low.

You'll find ERYTHROCIN highly effective against most coccal organisms. And it may well be the tool to counteract coccal complications following viral attacks.

Usual adult dose is 250 mg. four times daily. Dosage for children may be reduced in proportion to body weight. ERYTHROCIN comes in Filmtabs® (100 and 250 mg.), bottles of 25 and 100. Also available in tasty, cinnamon-flavored oral suspension; comes in 75-cc. bottles.

Abbott

® FILMTAB—FILM-SEALED TABLETS, ABBOTT; PAT. APPLIED FOR.

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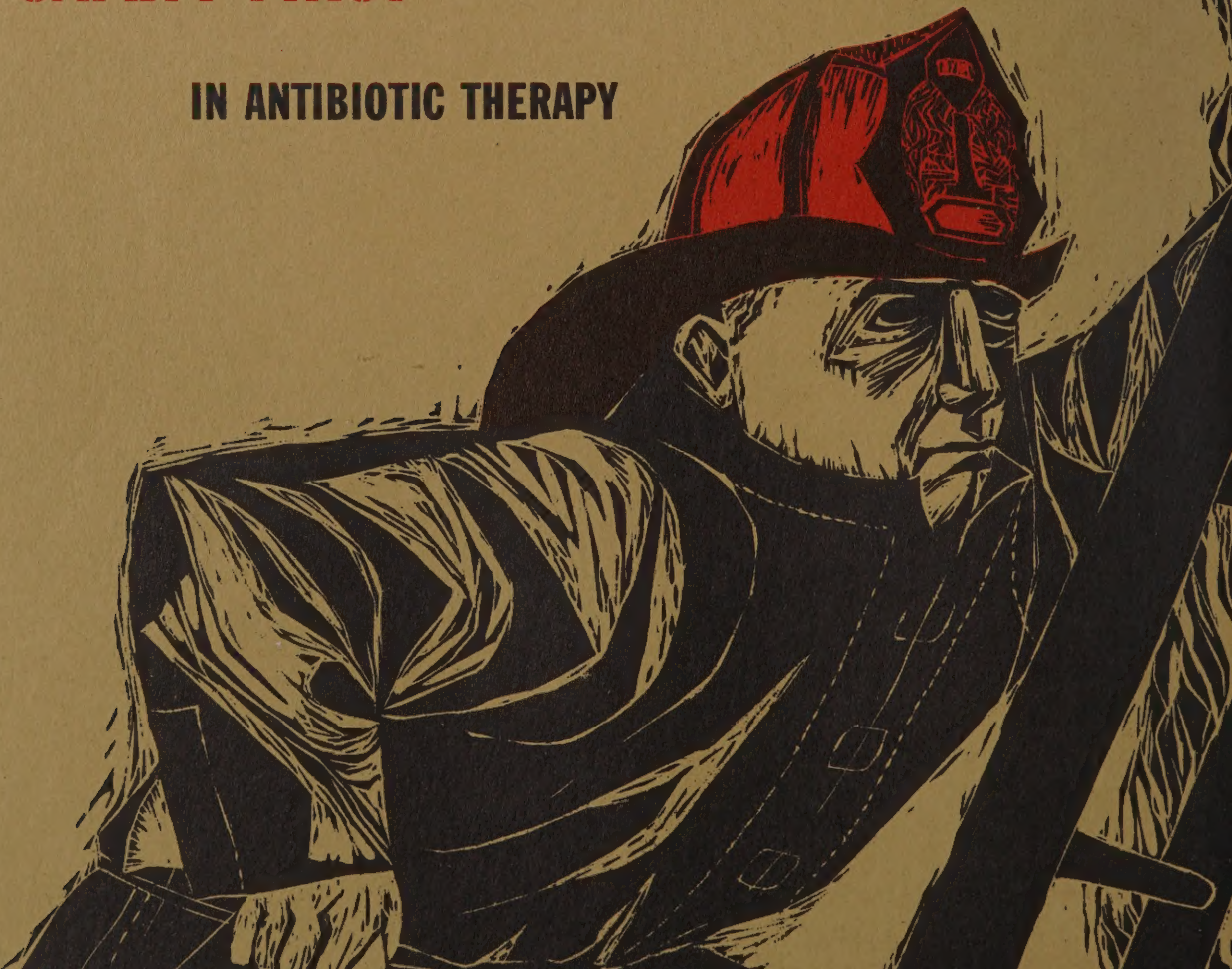
SAFETY FIRST

IN ANTIBIOTIC THERAPY



You and Your AMA

Some Highlights and Sidelights on the American Medical Association's Activities and Program

Newspaper for Physicians

The *AMA News,* which made its debut with the September 22 issue, is a fortnightly newspaper based on a new concept of reporting news of interest to America's physicians.

It was conceived after more than a year of inquiries, research and personal interviews with doctors. It is designed to fill the doctor's need for news of the medical community. It is edited in easy-to-read style for the busy physician.

Editorial content is non-technical, featuring articles of special interest to doctors in the medico-economic and socio-economic fields. It reflects all aspects of a physician's life, his work, his problems.

The News concentrates on articles not now carried in other AMA Journals. For example, scientific reports are news stories, many of them calling attention to detailed articles in *The Journal of the American Medical Association* and other publications.

Its purpose is practical—to help doctors figure out the day-to-day problems that go with practicing medicine, bettering the health of the community and the profession of medicine.

New Field Staff Member

Dr. M. Eleanor Blish of Houston, Texas, has been appointed a member of the field staff of AMA's Council on Medical Education and Hospitals. Dr. Blish has been in the private practice of pediatrics in Houston since 1944 and on the staffs of Baylor University College of Medicine and Children's Clinic at Houston Tuberculosis Hospital.

Misleading Advertising

Lending its support to a campaign to curtail offensive or misleading advertising of over-the-counter medications, the American Medical Association has become a member of the National Better Business Bureau.

NBBB will coordinate the work of voluntary organizations seeking to eliminate objectionable advertisements of some over-the-counter medical products.

The AMA organized a meeting in May, 1958, of drug manufacturers, advertising agencies, and radio, television, newspaper and magazine representatives. This group suggested that NBBB coordinate the voluntary program.

Immediate support for the program came from Richard L. Scheidker, senior vice-president of the American Association of Advertising Agencies, who told AMA, "We stand ready to work with you in any way that we can in the further development of a cooperative program."

Future Meetings

AMA's Board of Trustees approved Denver as host city for the association's 1961 clinical meeting. The 1959 session will be held in Dallas, the 1960 meeting in Washington, D. C.

World-Wide Qualifications

The first world-wide American Medical Qualification Examination was held Sept. 23 in 35 foreign countries.

Dr. Dean F. Smiley, executive director of the Educational Council for Foreign Medical Graduates, said the program seeks to provide a common denominator for examinations in more than 600 foreign medical schools.

Applications to take the exam have been filed by 1,136 persons.

The examination follows a round-the-world trip by Dr. John P. Hubbard, professor of Preventive Medicine at the University of Pennsylvania, to complete arrangements with proctors.

ECFMG opened its office in October, 1957, at 1710 Orrington Ave., Evanston, Ill., and gave the first examination to 298 foreign applicants with U. S. addresses in March, 1958. Examinations will be given twice a year, in Spring and Fall.

ECFMG is sponsored by American Hospital Assn., American Medical Assn., Association of American Medical Colleges, and Federation of State Medical Boards of the United States.

Reservations for Minneapolis

Physicians who have not done so already should make hotel reservations in Minneapolis for the coming 12th AMA Clinical Meeting, December 2 - 5. Blanks giving prevailing rates in leading Minneapolis hotels together with a blank to be sent to the housing bureau are appearing in current issues of the *AMA News* and *The Journal of the AMA.*

THE McMILLEN SANITARIUM

ROBERT A. KIDD, M.D. — *Psychiatrist-in-Chief*

Superb Accommodations

for

Acute and permanent Geriatric patients

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Acute female nervous disorders

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For the Diagnosis and Treatment of Psychiatric Disorders

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Limited Facilities for the Aging

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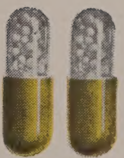
Now—the most widely prescribed tranquilizer[1] in sustained release capsules

Meprospan*

meprobamate (Miltown®) capsules

q. 12 h.



Two capsules on arising **last all day**
Two capsules at bedtime **last all night**
relieve nervous tension on a *sustained* basis, without between-dose interruption

"The administration of meprobamate in sustained action form [Meprospan] produced a more uniform and sustained action . . . these capsules offer effectiveness at reduced dosage."[2]

Dosage: 2 Meprospan capsules q. 12 h.
Supplied: 200 mg. capsules, bottles of 30.

[1] Meprobamate is more widely prescribed than any other tranquilizer. Source: Independent research organization; name on request.

[2] Baird, H. W., III: A comparison of Meprospan (sustained action meprobamate capsule) with other tranquilizing and relaxing agents in children. Submitted for publication, 1958.

Literature and samples on request

WALLACE LABORATORIES, *New Brunswick, N. J.*
who discovered and introduced Miltown®

*TRADE-MARK CME-7326

when you treat hypertensive patients

double duty RAUDIXIN

Squibb Standardized Whole Root Rauwolfia Serpentina

is the solid base line for successful therapy

Raudixin helps you relieve pressures in your patients

Raudixin "lowers blood pressure and slows the pulse rate much more efficiently than the barbiturates. . . . It is not habit-forming and is synergistic with all other known hypotensive drugs."*

Raudixin helps you relieve pressures on your patients

Raudixin "relieves anxiety and tension, particularly the tension headache of the mild hypertensive patient, better than any other drug."*

RAUDIXIN . . . "is the best symptom reliever."*

In mild to moderate cases, Raudixin is frequently sufficient.

Base line therapy with Raudixin permits lower dosage of more toxic agents. The incidence and side effects of these agents are minimized. Diuretics often potentiate the antihypertensive effect of Raudixin.

*Finnerty, F. A. Jr.: New York State J. Med. 57:2957 (Sept. 15) 1957.

SQUIBB CENTENNIAL 1858 1958 SQUIBB *Squibb Quality—the Priceless Ingredient*

'RAUDIXIN'® IS A SQUIBB TRADEMARK

COMPREHENSIVE CONTROL OF CONSTIPATION

PROVIDES SOFT STOOLS GENTLY STIMULATED TO EVACUATION

DOXINATE® with DANTHRON (Doxan)

— the original dioctyl sodium sulfosuccinate fecal softener combined with danthron, the non-irritating, non-habit forming laxative —

Comprehensive control of constipation with Doxan . . .

★ prevents fecal dehydration and gently stimulates the lower colon in functional constipation

★ synergistically provides, with a subclinical dosage, peristaltic action on a soft, "normal" intestinal content rather than on the hardened mass typical of constipation

★ results in soft stools gently stimulated to evacuation . . . and restores normal bowel habits

Doxinate with Danthron (Doxan) is supplied as brown, capsule-shaped tablets containing 60 mg. dioctyl sodium sulfosuccinate and 50 mg. 1,8-dihydroxyanthraquinone.

Usual adult dose: One or two capsule tablets at bedtime. Bottles of 30 and 100.

When fecal softening alone is indicated— Doxinate 240 mg.—provides optimal once-a-day dosage for maintenance therapy.

Doxinate is a registered trademark of Lloyd Brothers, Inc.

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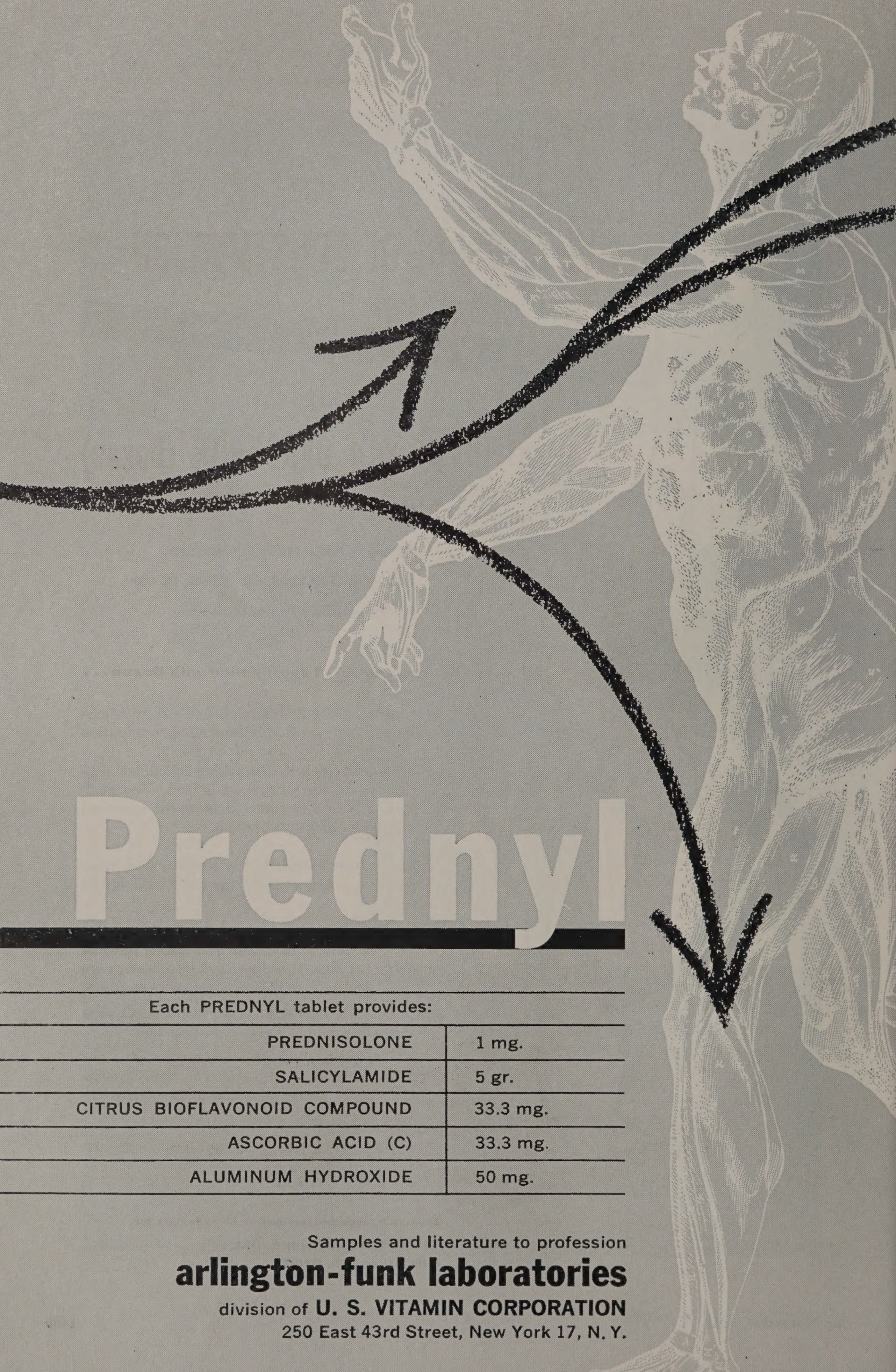
CINCINNATI 3, OHIO



Prednyl

Each PREDNYL tablet provides:	
PREDNISOLONE	1 mg.
SALICYLAMIDE	5 gr.
CITRUS BIOFLAVONOID COMPOUND	33.3 mg.
ASCORBIC ACID (C)	33.3 mg.
ALUMINUM HYDROXIDE	50 mg.

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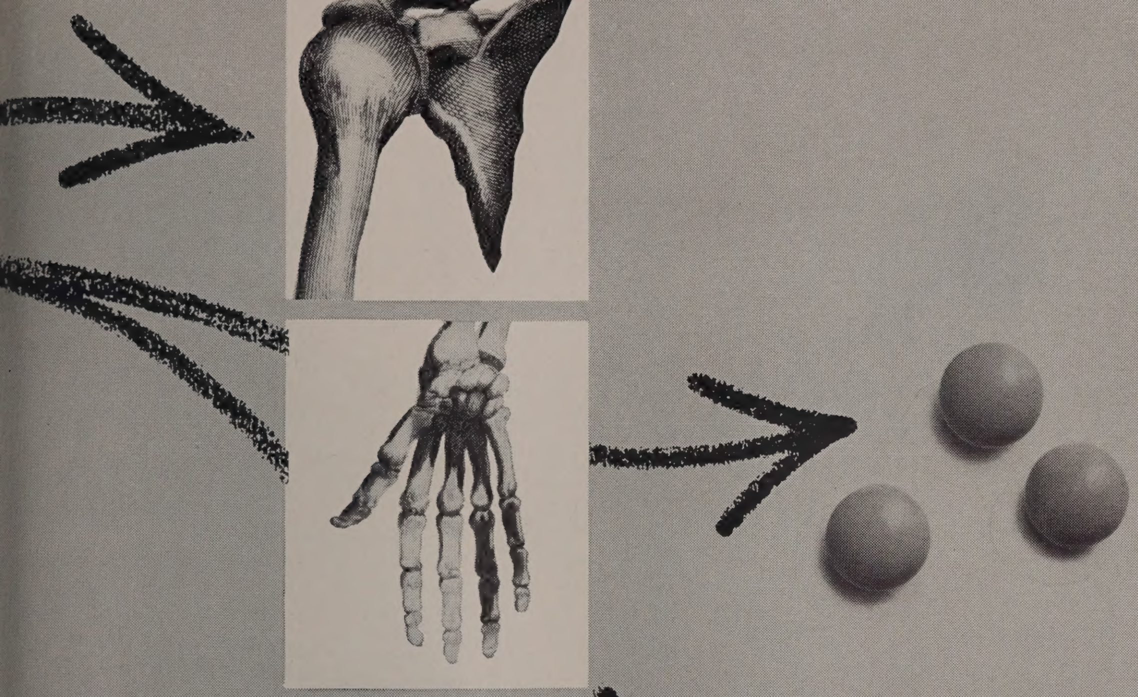

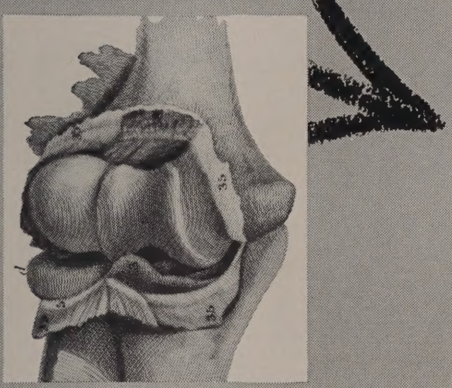

new, safer,
more comprehensive
anti-inflammatory,
antirheumatic,
analgesic

in rheumatoid arthritis, myositis, fibrositis, bursitis, and other inflammatory and rheumatoid conditions

PREDNYL affords prompt, dramatic relief from pain and muscle spasm, increased range of motion and often return to normal activity—because of . . .

3-way anti-inflammatory action: with potent prednisolone, water-soluble citrus bioflavonoid compound, salicylamide.

greater antirheumatic, analgesic effects: with less prednisolone and less salicylate than when either is given alone — minimizing risk of steroidism or salicylism.

protection: against steroid-induced capillary hemorrhage, gastric distress, vitamin C depletion.

dosage: Average, 1 to 3 PREDNYL tablets q.i.d., with gradually reduced dose to effective maintenance level. Bottles of 100 and 500.

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PARKING
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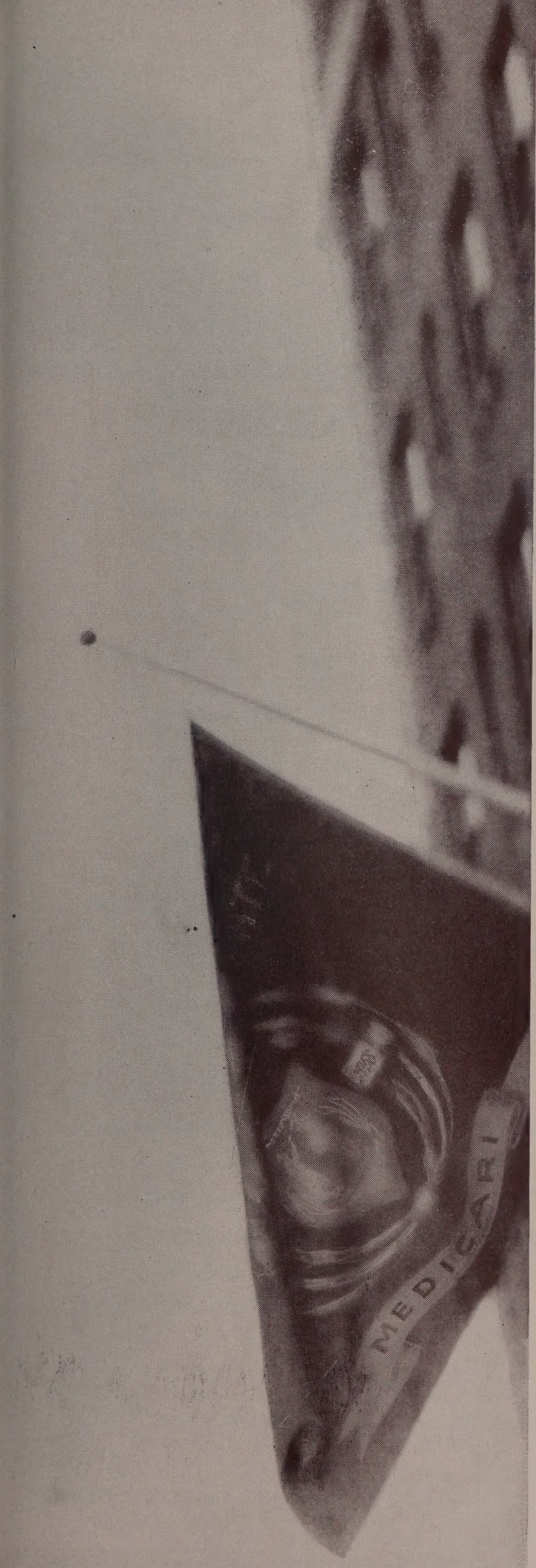
7AM - 7PM
QUIET



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Tetracycline and Citric Acid Lederle

A Decision of Physicians

When it comes to prescribing broad-spectrum antibiotics, physicians today most frequently specify Achromycin V.

The reason for this decided preference is simple.

For more than four years now, you and your colleagues have had many opportunities to observe and confirm the clinical efficacy of Achromycin tetracycline and, more recently, Achromycin V tetracycline and citric acid.

In patient after patient, in diseases caused by many invading organisms, Achromycin achieves prompt control of the infection—and with few significant side effects.

The next time your diagnosis calls for rapid antibiotic action, rely on Achromycin V—the choice of physicians in every field and specialty.

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a Division of
AMERICAN CYANAMID COMPANY
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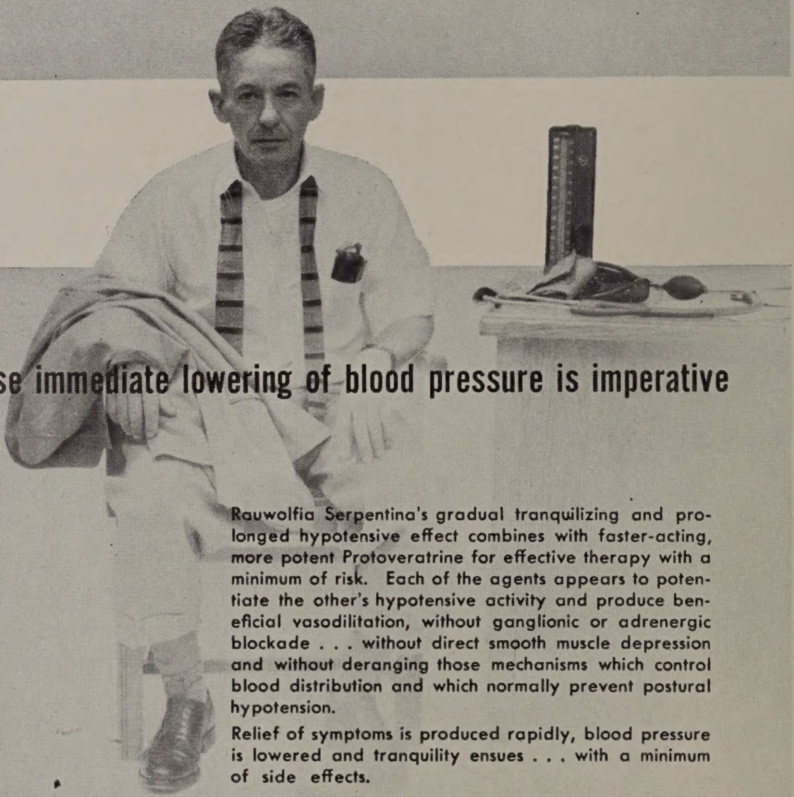
diagnosis: **hypertension, moderate to severe**

prescribed: **Rauprote***

(Rauwolfia Serpentina and Protoveratrines A & B Combined)



because immediate lowering of blood pressure is imperative

Rauwolfia Serpentina's gradual tranquilizing and prolonged hypotensive effect combines with faster-acting, more potent Protoveratrine for effective therapy with a minimum of risk. Each of the agents appears to potentiate the other's hypotensive activity and produce beneficial vasodilitation, without ganglionic or adrenergic blockade . . . without direct smooth muscle depression and without deranging those mechanisms which control blood distribution and which normally prevent postural hypotension.

Relief of symptoms is produced rapidly, blood pressure is lowered and tranquility ensues . . . with a minimum of side effects.

supplied: in bottles of 100 and 1000 tablets, each containing 50 mg. Rauwolfia Serpentina and 0.2 mg. Protoveratrines A and B (the chemically standardized alkaloid of Veratrum Alba), or on prescription at leading pharmacies

VALE **THE VALE CHEMICAL COMPANY, INC.** *allentown, pa.*

PHARMACEUTICALS

*Trade Mark

for depression

▲Deprol▲†

Clinically confirmed in over 2,500 documented case histories[1,2]

CONFIRMED EFFICACY

Deprol ► acts promptly to control depression *without* stimulation

► restores natural sleep

► reduces depressive rumination and crying

DOCUMENTED SAFETY

Deprol is unlike amine-oxidase inhibitors

► does not adversely affect blood pressure or sexual function

► causes no excessive elation

► produces no liver toxicity

► does not interfere with other drug therapies

Deprol is unlike central nervous stimulants

► does not cause insomnia

► produces no amphetamine-like jitteriness

► does not depress appetite

► has no depression-producing aftereffects

► can be used freely in hypertension and in unstable personalities

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: Each tablet contains 400 mg. meprobamate and 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl).

Supplied: Bottles of 50 scored tablets.

1. Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. **166**:1019, March 1, 1958. **2.** Current personal communications; in the files of Wallace Laboratories.

†TRADE-MARK

CD-7486

Literature and samples on request W® WALLACE LABORATORIES, *New Brunswick, N. J.*

Washington Roundup . . .

News from the Nation's Capital of Interest to Physicians; Developments in Medical and Health Fields

The Army Medical Service has activated a new Research and Development Command, with headquarters in Washington. It will serve as the focal point of the Army Medical Service's world-wide program which seeks to provide better preventive medicine measures and more effective and more rapid treatment techniques.

* * *

AMA and allied groups won an important administrative victory in inducing the Post Office Department to rescind a move to ban airmail shipments of etiological disease agents as a protection for crews and passengers. U. S. Public Service's new requirements for packaging such agents was a major factor in getting ban dropped.

* * *

HEW Secretary Flemming reports 43 stations in the states and territories are measuring radioactivity, 45 are testing water and nine are sampling milk. Feed samples packed in 1945 have been collected to gather data on radioactivity changes since that year in which the first nuclear test was held.

* * *

National Institute of Dental Research reports "no significant differences" attributable to fluoride intake could be found in microscopic examination of 99 bones from 37 persons who had drunk for years water containing 1 to 4 ppm. fluoride and bones of 33 controls from areas where water had less than 0.5 ppm.

* * *

Budget Bureau reports OASI and disability payments for the last year at $9.49 billion, with receipts estimated at $8.35 billion, which is $1.14-billion under payments. This difference is expected to be offset by increase in tax rates January 1, 1960.

* * *

United Mine Workers Welfare and Retirement Fund's annual report claims $1,448,909 (2.4 per cent) over previous year in total cost of hospital and medical care, "notwithstanding the sharp increase in such costs throughout the nation."

VA reports development of a device enabling the blind to "read" ordinary printing. An instrument focuses a light beam on the printing and from the printing produces a pattern of musical chords. A blind person trained to interpret the sounds as words and letters, VA says, will have a reading speed of 15 to 30 words a minute.

* * *

National Institutes of Health allocated $42,665,767 in research grants and fellowships during July and August, representing 2,793 awards. National Heart Institute will administer 588 of the research awards, totalling $8,777,094.

* * *

Public Health Service, following request of National Conference on Nursing Homes for Aged and Association of State and Territorial Health Officers, is designing model legislation and regulations for nursing homes and homes for the aged, which would serve as guide to states and territories interested in revising their laws and rules.

* * *

Latest figures show Hill-Burton projects have passed 4,000 mark. Since 1946, estimated cost of 4,035 approved projects totals $3,373,252,068, of which Federal share is $1,042,108,206. This represents, among other facilities, an increase of 173,059 hospital beds.

* * *

VA is accepting bids for $20 million, 1,000-bed neuro-psychiatric hospital to be erected in Brecksville, Ohio, adjacent to Cleveland. Plans call for following square footage: 139,478 for general medical-surgical-administration building; 123,191 for admission and treatment building; 52,145 each for two continued treatment buildings, and 73,174 for disturbed patients' building.

* * *

Scientists hope to get answers to puzzle of never-measured role of gravity in life's processes by placing 5,000 yeast cells in a satellite to be fired into orbit this fall. Growth of the yeast will be measured for clews to biological effects of weightlessness, cosmic radiation and other space phenomena.

9
HOLE IN ONE

LEAVES NOTHING TO BE DESIRED

HYCOMINE® Syrup

THE COMPLETE Rx FOR COUGH CONTROL

cough sedative / antihistamine / expectorant

- relieves cough and related symptoms in 15-20 minutes
- effective for 6 hours or longer • promotes expectoration
- rarely constipates • cherry-flavored

Each teaspoonful (5 cc.) contains:
Hycodan®
Dihydrocodeinone Bitartrate .... 5 mg. } 6.5 mg.
(Warning: May be habit-forming)
Homatropine Methylbromide .... 1.5 mg.
Pyrilamine Maleate .... 12.5 mg.
Ammonium Chloride .... 60 mg.
Sodium Citrate .... 85 mg.

Adult Dosage: one teaspoonful q. 6 h. May be habit-forming.
Federal law permits oral prescription.

Endo

Literature on request
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Richmond Hill 18, New York

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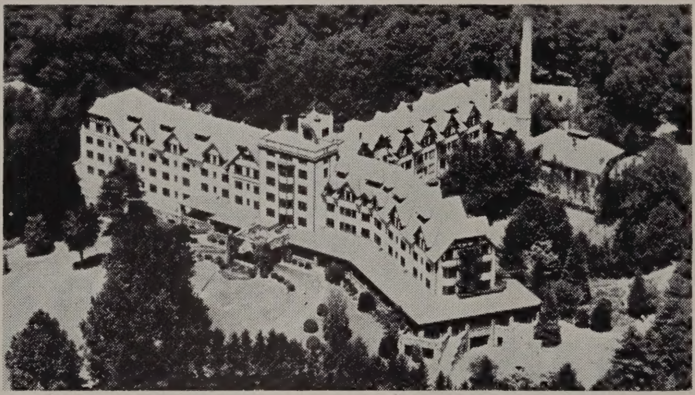

An institution for the diagnosis and treatment of psychiatric and neurological illnesses, rest, convalescence, drug and alcohol habituation. There are ample facilities for classification of patients.

Insulin coma, electroshock, psychotherapy, occupational and recreational therapy are employed. The hospital is equipped with complete laboratory facilities, including electroencephalography and x-ray.

Appalachian Hall is located in Asheville, North Carolina, a resort town in the beautiful Smoky Mountain Range, an ideal location for rehabilitation.

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For rates and further information write APPALACHIAN HALL, Asheville, N. C.

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FOR GERIATRIC PATIENTS WHO NEED MEDICAL ATTENTION AND NURSING CARE, AWAY FROM HOME

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Phone 2-1606 or Write

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Provides balanced nutritional values

1. Fibre-free **HYPOALLERGENIC** formula.
2. An excellent formula for regular infant feeding.
3. An ideal food for milk allergies, eczema and problem feeding.

SOYALAC helps solve the feeding problem of prematures and infants requiring milk-free diet.

Strikingly similar to mother's milk in composition and ease of assimilation, babies thrive on SOYALAC.

Clinical data furnish evidence of SOYALAC'S value in promoting growth and development.

Protein of high biologic value is obtained from the soybean by an exclusive process.

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CONCENTRATED
LIQUID
Hypoallergenic
For Infants
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Loma Linda FOODS

Free Booklet and Samples

A request on your professional letterhead or prescription form will bring to you complete information, and a supply of samples. Please address the Loma Linda Food Company, Arlington, California, or Mount Vernon, Ohio.

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NEW . . . **intranasal synergism**

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Biosynephrine

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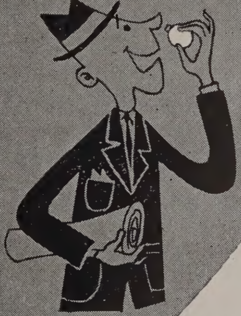
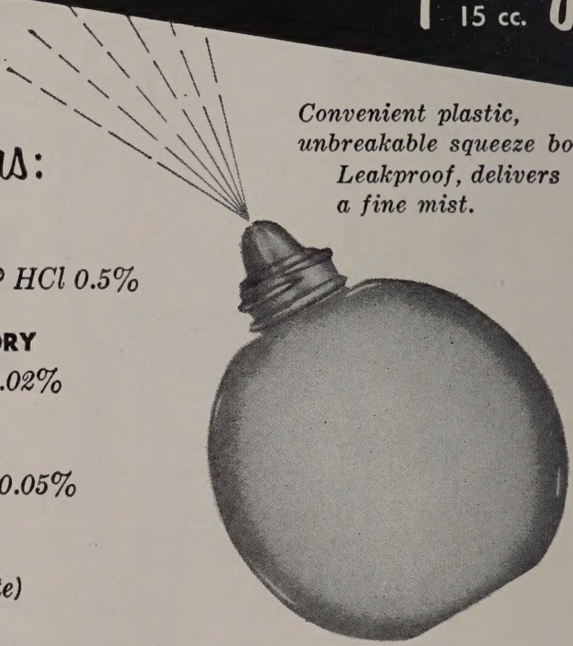
15 cc.





Convenient plastic, unbreakable squeeze bottle. Leakproof, delivers a fine mist.

Contains:

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Neo-Synephrine® HCl 0.5%

ANTI-INFLAMMATORY
Hydrocortisone 0.02%

ANTI-ALLERGIC
Thenfadil® HCl 0.05%

ANTIBACTERIAL
Neomycin (sulfate) 1 mg./cc.
(equivalent to 0.6 mg. neomycin base/cc.)

Polymyxin B (as sulfate) 3000 u/cc.

POTENTIATED ACTION for better clinical results

in **COLDS**
SINUSITIS
ALLERGIC RHINITIS

Winthrop LABORATORIES
NEW YORK 18, N. Y.

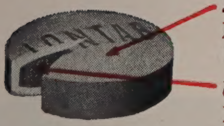
Neo-Synephrine (brand of phenylephrine) and Thenfadil (brand of thenyldiamine), trademarks reg. U.S. Pat. Off.

X-RAYS SHOW HOW ONE PYRIBENZAMINE® LONTAB®

relieves allergy all day or all night

The unretouched X-ray films show how Lontabs release medication in the digestive tract. So that the prolonged erosion of the Lontab core could be visualized by X-ray, subject was given 10 Lontabs, each containing 100 mg. of a radiopaque substance in place of Pyribenzamine.

With its unique formulation, the Pyribenzamine Lontab not only relieves allergy symptoms promptly, but sustains relief as long as 12 hours.



Special outer shell releases 33 mg. Pyribenzamine hydrochloride within 10 minutes.

Unique core releases approximately 18 mg. Pyribenzamine hydrochloride the 1st hour, approximately 50 mg. from the 2nd to the 12th hour.

SUPPLIED: Pyribenzamine *Lontabs* – full-strength – 100 mg. (light blue).

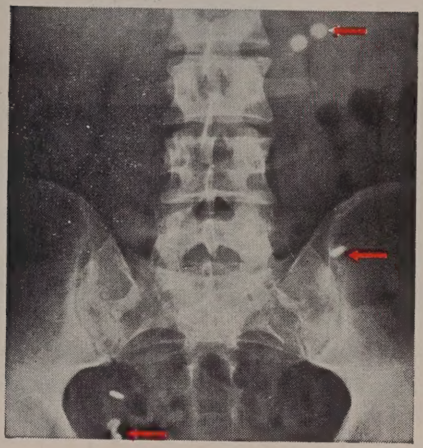
NOW AVAILABLE: Pyribenzamine *Lontabs* – half-strength – 50 mg. (light green) – for children over 5 and for adults who require less antiallergic medication.

PYRIBENZAMINE® hydrochloride (tripelennamine hydrochloride CIBA)
LONTABS® (long-acting tablets CIBA)

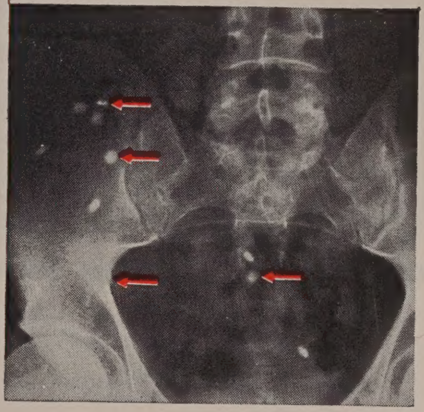
@/2562MK

C I B A SUMMIT, N. J.

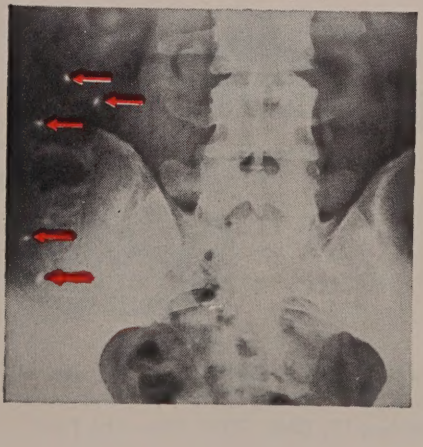
2 hours Lontabs are in the stomach and small bowel. Release of core substance is well under way.



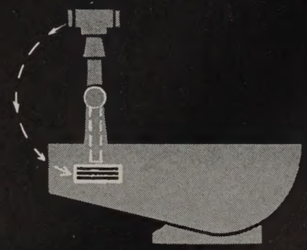
4 hours Lontabs are in the ileum and cecum as core has steadily eroded.



8 hours Lontabs are still visible as substance of core continues to be released.



probably the easiest-to-use x-ray table in its field



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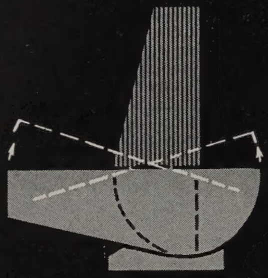

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72	72	72	37	37	37	37	37	37	37	30	30	37	37	37	37	37	37	37	37		
CHEST		SPINE					PELVIS FETUS		HEAD			EXTREMITIES		SHOULDER RIBS		GALL BL'R G.U. TRACT	Gastro-Intestinal				

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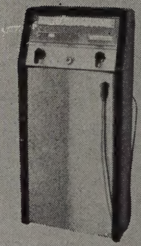

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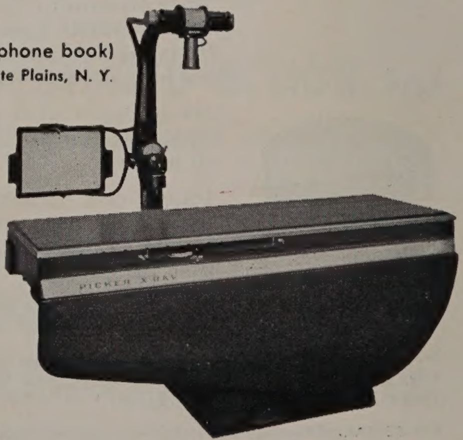

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In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

NEW OSMA POLICY SETS SPECIFIC ETHICAL GUIDELINES

Each member of the Association received with the October *OSMAgram,* a booklet in which appeared the statement by The Council on the unauthorized practice of medicine by corporations, and others, adopted on June 8, 1958.

This was distributed for the guidance of the membership and to assist county medical societies in dealing with local problems of this nature.

Commenting on this the *Cincinnati Journal of Medicine* offered the following pertinent advice:

"The action taken by the Ohio State Medical Association is timely because it tends to establish a specific policy for physicians when either the unauthorized practice of medicine is involved or it is necessary to clarify the procedure in billing patients. Physicians have expressed concern over the latter wherein it is assumed that either a hospital, corporation, third party pay group, or unauthorized person has the right to make a charge for services that can be rendered only by the physician. The State of Ohio, through legal enactment, has placed the responsibility of the treatment of patients in the hands of the medical profession.

"Under the announced policy of the Ohio State Medical Association, the physician's culpability for unethical practice is specifically outlined. It would be well for physicians to review their relationship with hospitals, corporations, third party pay group, or other lay persons to establish their practice on sound, ethical principles. In the days to come, there will be much discussion about corporate, panel, and unauthorized practice of medicine."

JOIN THE PARADE OF AMEF CONTRIBUTORS

Four thousand Ohio physicians can't be wrong!

Approximately that's the number who contributed over $165,000 for medical education in 1957, either through the American Medical Education Foundation or directly to Alumni Funds.

Presumably most of these proponents of the present system of medical education will contribute to the cause again this year—1958.

They invite their colleagues to join them in the 1958 campaign which began October 1. Somewhere on your desk, if you haven't already used it, is a postpaid envelope addressed to AMEF. Fill out your check and mail it today.

You may prefer to make your donation to the Alumni Fund of your own medical school. If you wish you may earmark your AMEF contribution for a particular school. In either case, DO IT NOW.

The AMEF address is 535 N. Dearborn St., Chicago, Ill.—just in case you have misplaced it.

FIRING THE BULLETS IS A LOCAL JOB

The San Francisco County Medical Society claims the field of medical public relations is primarily a local problem and responsibility. Moreover, it states that the AMA and the state societies should streamline their PR activities and not insist on "package programs," leaving it to local areas to tailor PR work to local needs, with national and state help, if necessary.

With all of this we heartily agree. The state society should act as a clearing house on PR and a source of PR material and hunches. The firing-line job has to be done locally.

That being the case, the local medical society has a serious responsibility and challenge. If it wants to do the job in its own way, that's fine—providing it gets the job done.

SOME PUBLIC HEALTH FACTS AND COMMENTS

Four factual statements in a review of public health activities in Ohio for the year 1957, published by the Ohio Department of Health, are worthy of special comment.

* * *

At the close of 1957 there were more full-time, qualified health districts (69) than part-time, unqualified, (63). Altogether, 83.5 per cent of the state's population is now being served by competent, full-time health departments.

Comment No. 1: Isn't it time for the 16.5 per cent of the population which is being served by unqualified, part-time health departments to do something about this? Do they know that they are playing with fire in not bringing their health department up to a qualified status?

* * *

During 1957, the total amount appropriated for local health departments increased $483,000, the total being $11,568,376—a 4.4 per cent increase.

Comment No. 2: The package picture appears good but what about the 44 health districts which appropriated less in 1957 than in the previous

Low Dosage KYNEX* for G.U. Infections

Sulfamethoxypyridazine Lederle

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Unusual Antibacterial and Anti-infective Properties—More soluble in acid urine[1] . . . higher and better sustained plasma levels than any other known and useful antibacterial sulfonamide.[2]

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Dosage: The recommended adult dose is 1 Gm. (2 tablets) the first day, followed by 0.5 Gm. (1 tablet) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours.

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Tablets: Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

Syrup: Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

references:
1 Grieble, H.G., and Jackson, G.G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958
2. Editorial: *New England J. Med.* 258:48-49, 1958.

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*Reg. U. S. Pat. Off.

year? That doesn't appear to be in keeping with the times which demand more and better public health activities.

* * *

During 1957, Ohio's financial support of the Ohio Department of Health decreased. In fact, 39 per cent of the ODH's operating fund in 1957 was derived from Federal sources. This was a 6 per cent increase—a reversal of the pattern of the four previous years.

Comment No. 3: Let's don't get back into the old rut of letting the Federal Government do a job which the people of Ohio ought to be doing. The trend was changed a few years back. Let's get back on the beam.

* * *

Total spent on public health services in Ohio in 1957—state and local—was $15,618,506, an increase of $1.5 million over 1956 and a per capita expenditure of $1.70, up 6 cents from the preceding year.

Comment No. 4: Shows progress but still not good enough for a growing, thriving state like Ohio.

HOW WELL DO YOU KNOW YOUR SYMBOLS?

Do you know what the official symbol of the AMA is and what it means?

The official symbol of the AMA adopted in 1910 is the staff of Aesculapius, composed of a rod encircled by a single serpent. The knots in the staff are supposed to represent the "knotty" problems of medicine. The serpent typifies wisdom. The serpent is also a symbol of healing, since it sloughs off its skin periodically, and thus, symbolically as well as actually, renews its life. Scarlet and gold colors are employed. In the days of alchemy the elixir of life was a red tincture and the key of wisdom a red powder. The gold represents the sun, long regarded as a healing influence.

In ancient mythology, Aesculapius—the son of Apollo and the nymph Coronis—was the god of medicine or healing. The Greeks called him Asklepios, the Romans Aesculapius.

One legend has it that Aesculapius was attending Glaucus when the latter was struck dead by a thunderbolt. When a serpent crept into the room where the man lay, Aesculapius killed it with his staff. Another serpent entered the room and put herbs at the mouth of the first serpent which was then brought back to life. Aesculapius then revived Glaucus with the same herb. Alarmed that Hades was being depopulated, Pluto requested Jupiter to destroy the great doctor with a thunderbolt. At Apollo's request, however, Aesculapius was made immortal and placed among the stars in the southern heavens as Ophiuchus, the snake bearer.

The sacred snakes became synonymous with the god of healing, and the Aesculapian staff was invariably connected with medicine. Temples were erected throughout the ancient world. Aesculapius usually is depicted standing in a long flowing toga with his right hand clasping the staff along which a single serpent twines its way upward.

CLEANUP OF TV "DOCTORS" BADLY NEEDED—AND PROMPTLY

Most physicians, in our opinion, will say a fervent "amen" to the following editorial published by the *New York Times*. The housekeeping job suggested won't be easy to accomplish, but it certainly should be worth the try. Said the *Times*.

"The New York State Medical Society should be commended for adopting a resolution that calls on the American Medical Association to make further efforts to stop the abuse of the word 'doctors' on radio and television commercials. We hope that some pressure can be brought to oblige the networks and their sponsors to do some badly needed housecleaning.

"What is coming over the air now is an insult to the intelligence of the listener and viewer, a slur on the medical profession and an outright danger to the gullible. Any studio announcer can put on a white coat and solemnly declare that 'science shows.' Outrageous and nauseating charts of what purports to be the human anatomy are paraded under the heading of 'clinical tests prove.' And always there are those 'four out of five doctors' who agree to something. And always there is the nostrum that is twice as fast, or three times better, or satisfaction guaranteed or money back.

"There has been some minor straightening out of the cigarette advertising (although it still hasn't got around to grammar) and the cosmetic advertising is usually exaggerated and objectionable rather than dangerous. But the patent medicine show still goes on full blast. Most of the products are probably harmless enough, in all conscience. But it is always possible that some misguided persons will be impressed by the TV 'doctors' and go to patent medicine instead of to a real doctor.

"It is a sorry commentary on our enlightenment when the old 'snake oil' technique can be used on millions of persons to make millions of dollars in profits. Some of the advertising is so obviously false and unscrupulous, even if it happens to stay within the letter of the law, that remedial measures must be taken. It will be better for all concerned if they are taken by the industry itself rather than by government. It is high time to take those phony 'doctors' off the air."

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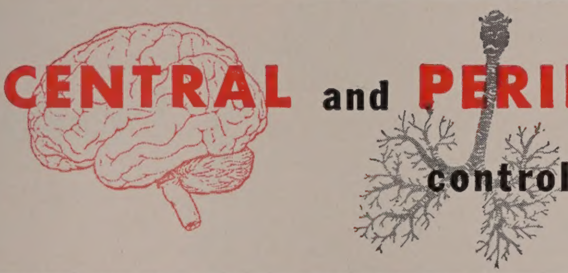

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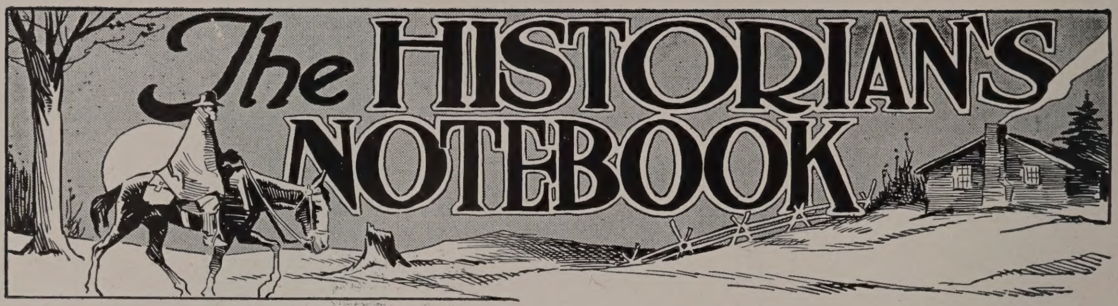

First Physician Settled in Mansfield, Ohio, in 1815

ELIZABETH REED, M. D.

THE War of 1812 and its constant threat of Indian raids discouraged the migration of new settlers to Richland County. During that period the nearest available physicians were Drs. Irvine and Burr at Mt. Vernon.

The end of the war, in 1815, brought the first two doctors to the county, one to each of the major settlements (Mansfield and Newville). Both were apparently above the average of the physicians of a day when there were few medical graduates and the majority of the "doctors" had at best a three-year apprenticeship with a practicing physician.

This consisted of helping care for the doctor's horses, sweeping out his office, and delivering his pills and powders. In return the student was permitted to read the medical books and was given some instruction in "bleeding," diagnosis, "pill-rolling," and the primitive surgery of the day. It was even possible to buy a "medical book" of which the last page was a diploma. The purchaser read the book; wrote his name on the diploma—and was ready for patients.

Father Was Pastor

Dr. Royal Powers was Mansfield's first physician. His father was a pioneer Baptist preacher in Western New York State; and his red-haired schoolteacher sister Abigail in 1826 married Millard Fillmore, later President of the U. S. Dr. Powers tore down the historic first cabin of Mansfield and erected a frame building of about 18 by 26 feet.

Here he "swung his shingle, kept a few drugs and practiced medicine," on the site of the present H. L. Reed store. Dr. Powers remained in Mansfield a few months and moved north to Huron County where he and his brother laid out the town of New Haven. He opened a general store there and became a fairly prosperous merchant.

The Author

● **Dr. Reed, Butler, Ohio, is in general practice there. Her hobby has always been Medical History.**

Dr. Robert Irvine located just east of Newville, also in 1815; and was the county's only physician from Dr. Powers' departure till 1818. He was born in Ireland in 1764; was a cousin to the Earls of Belmore and Enniskillen, and was descended from an officer in King William's army at the Battle of the Boyne (1690).

After graduation in Medicine at Trinity College, Dublin, he brought his new bride to America in 1787. He located first in Western Pennsylvania on the advice of his uncle, Gen. William Irvine (American commander at Fort Pitt during the Revolution). In 1811 he followed the pioneers to Mt. Vernon and there opened his own drugstore. This was quite usual in the early days when it required four to five months to get drugs ordered and shipped over the mountains from Philadelphia.

Life Too Harsh

Dr. Irvine practiced medicine in Richland County for about five years. The absence of roads and bridges and the long distances between patients proved discouraging to a man in his 50's. He said, "This Ohio country is too uncivilized," and returned to Mercer County, Pa., where he died in 1826. Like most of the very early physicians he was interested in land speculation; and his children inherited the western half of Mercer County.

Medical fees were remarkably low at this period.

Reprinted from the Sesquicentennial Edition of the *Mansfield News-Journal,* Mansfield, Ohio, July 13, 1958.

Dr. Daniel Drake of Cincinnati, founder of the first medical school in Ohio, quotes examples:—Medicines, 25 cents to $1; bleeding, 25 cents; sitting up all night with a patient, $1; Visits, 25 cents per mile—half being deducted and the other half paid in horsefeed or food for the doctor's family. There was almost no money on the frontier and what there was went to the tax collector. Thus most of our early physicians, like Abijah Beach, M. D., who came to Bellville in 1826, were forced to combine various mercantile and land speculations with their medical practice.

Dr. Beach was very successful. In 1857 he made an extensive tour of the hospitals of Europe and in 1868 opened his own hospital in Bellville (The County's first!) After 1877 he retired from medicine and operated "a large grocery and notions store" in Bellville.

Dr. Moore B. Bradley was probably the second physician of Mansfield. He came here in 1818 and bought one-half of Lot 97 which had earlier belonged to Dr. Powers, and was located on "West Diamond." (Now Main St.) He left Mansfield with his wife Reumah in 1822; and moved to Waterford, Erie County, Pennsylvania. Ten years later he was a member of the first Vestry of the Episcopal Church there. Ohio seems to have been too wild for him too.

Arrived in 1822

Dr. Allen G. Miller came in 1822, and his brother practiced with him. A. G. Miller continued here for 25 to 30 years and trained some of the later physicians. One Dr. Sweney was also in Mansfield before 1828, probably for a very short time.

Dr. William Bushnell came to Mansfield in 1828. He had studied medicine with a doctor in Trumbull County, and finished with a year at the Ohio Medical College at Cincinnati, after which he practiced medicine and taught school in New Orleans for a year. He was a prominent physician here for more than 50 years. He was a director of the Atlantic and Great Western railway; was interested in the old Richland County Historical Society; and served several terms in the Ohio House of Representatives. In 1878 he was appointed Ohio delegate to the International Congress on Prison Reform at Stockholm, Sweden.

In 1850 Mansfield had 31 physicians for a population of 1,733, or one doctor for each 55 potential patients. This was a definite over-supply, and in 1858 the number had dropped to 15.

Seven Served in Civil War

The Civil War brought more changes. At least seven Mansfield physicians served as Army surgeons; Drs. Cantwell, Keys, McMillen, Mitchell, Mowry, Patterson and Race.

Dr. J. Young Cantwell was born on Spring Mill Rd., near Mansfield in 1824; read medicine with Dr. J. M. Chandler in Mansfield until 1847, when he opened his own office here. He served as operating surgeon in more than 20 battles with the 82nd Ohio Volunteer Infantry, of which his brother James was colonel. In 1864 he was appointed inspector of hospitals for the Union Army and made Lieutenant Colonel. After the war he went to Alabama in the "Carpetbagger" era, but finally returned to Mansfield. Dr. David McMillen of Mansfield served as surgeon of a "Hospital Boat" on the Ohio and Tennessee Rivers. These boats carried the wounded back to established hospitals.

Among the doctors of the 1850 - 1900 period were Dr. George Mitchell and his son George Jr., and the Drs. James Craig, father and son (located where the De Yarmon Insurance Co. is now). Dr. A. J. Erwin came to Mansfield in 1870. He studied at the Royal London Ophthalmic College; commuted from here to teach at the Cleveland Medical College, and had a sizable box of cataracts he had removed.

Three "Fifty Year Men"

The Richland County Medical Society has three "Fifty Year Men" (Doctors in practice more than 50 years): Drs. J. L. Stevens and Ralph Wise of Mansfield and John A. Reed of Butler.

Dr. Wise, prominent eye, ear, nose, and throat specialist, graduated from Jefferson Medical College in Philadelphia in 1901. He practiced in his hometown of Millersburg until 1911, when he moved to Mansfield. He has been in practice for 57 years, 47 of them in Mansfield.

Dr. John L. Stevens, long Mansfield's leading surgeon, graduated at Starling Medical College in March of 1895 and located in Mansfield in April of that year. The first year he walked about the town to make his calls; the following year he bought a bicycle; and after two years in practice he bought a horse and became a full-fledged "horse and buggy doctor." He studied surgery in Europe and was one of the pioneers in the use of x-ray. He has been in active practice for 63 years, a remarkable record of achievement and endurance.

At the present time there are 88 physicians listed in the Mansfield directory, with men trained in nearly every possible specialty. Medicine has changed remarkably since young Dr. Powers first rode into the town with his saddle-bags bulging with pills and powders.

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BECKER, M. C., Simon, F. and Bernstein, A.: J. Newark Beth Israel Hosp. **9**:58 (January) 1958.

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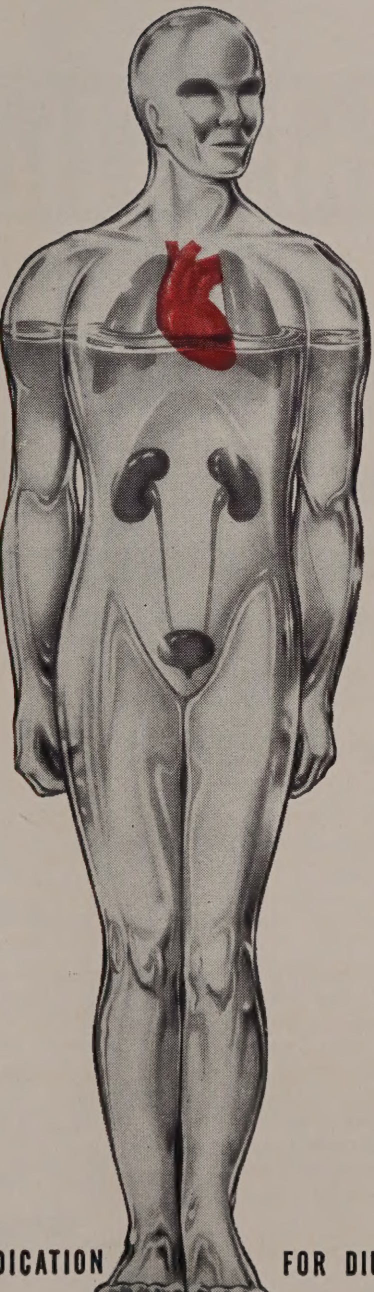

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*Chappel, C.C., J.A.M.A., 162: 1414, (Dec. 8) 1956

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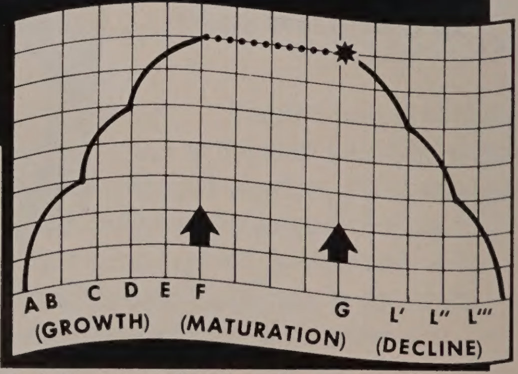

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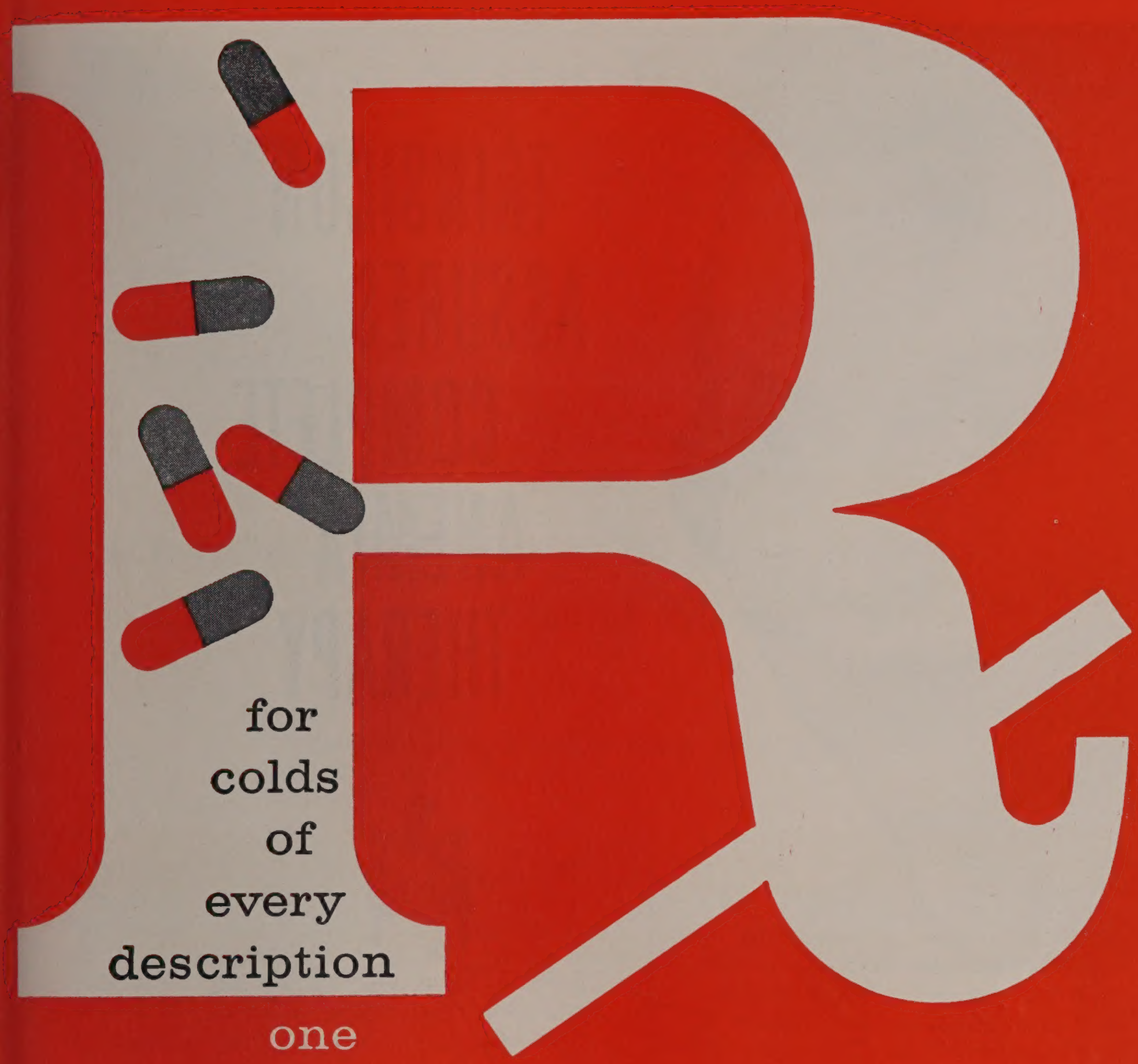

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CHARLES S. NELSON,
Managing Editor — Bus. Mgr.

R. GORDON MOORE,
Asst. Managing Editor

Tolbutamide: A Review of Its Mechanism and Its Role In Clinical Practice

GEORGE J. HAMWI, M. D., and RICHARD A. SERBIN, M. D.

SULFONAMIDE derivatives that have a hypoglycemic action have had extensive trial for the past several years both in this country and in Europe. In spite of intensive laboratory investigation the essential mechanism of action remains obscure. However, the clinical uses and limitations are becoming defined more adequately.

It is our purpose to present the salient facts known about these compounds and to describe the clinical results in our hands since one of these compounds, tolbutamide, became available to us in November, 1955.

Mode of Action

Janbon in 1942[1] was the first to notice the hypoglycemic effects of arylsulfonurea drugs during the course of his investigation of their antibiotic effects. In one of his studies on typhoid fever several of the subjects evidenced weakness, sweating and hunger which were shown to be due to a rather lowering of the blood sugar. Further investigation by Loubatieres[2] over the next several years established much of what is known about the action of these compounds.

It was found that the action of these drugs depended on the presence of islet cells, particularly the beta cell, of the pancreas. It has been repeatedly shown that this is true. There have been many opinions that the mechanism of action of these agents via the pancreas is to stimulate the remaining beta cells to increase their secretion of insulin. This question has not been completely resolved. Although it is generally agreed that the hypoglycemic effect is dependent on the presence of the pancreas, there is much evidence that the blood sugar lowering effect is not due to an increased secretion.

Increased carbohydrate utilization in the periphery has not been conclusively shown. On the contrary, studies using sugars other than glucose, such as D-xylose and L-arabinose, have shown that their peripheral utilization is not increased by the use of tolbutamide as it is with the use of insulin,

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in spite of a similar depression of blood glucose with the two agents[3]. This indicates that the action of the drug is not simply a matter of stimulating the production of the insulin by the pancreas.

Furthermore, in spite of the fact that both tolbutamide and insulin have blood sugar lowering effects, blood pyruvate levels are markedly different[4]. On the other hand, degranulation of the beta cells of the Islands of Langerhans of the animals after the administration of tolbutamide probably indicates that insulin has been released from the pancreas[5]. Until an increase in the concentration of insulin itself in the effluent blood stream of the pancreas can be demonstrated, direct proof of this very important problem cannot be given.

It has been postulated that the administration of the arylsulfonureas in some fashion interferes with the processes of insulin breakdown either through the mechanism of inhibiting "insulinase" or interfering with the other mechansims of insulin degradation[6]. The same body of evidence that has been marshalled against the insulin stimulating theory would apply equally here, as the net effect would be to increase the action of insulin. However, several investigators have shown that in animals which have been completely depancreatized for prolonged periods of time and which have been maintained on insulin, Orinase® has potentiated hypoglycemia[7]. While this piece of evidence does fit with the theory of inhibition of insulin destruction, it does not exclude other potential modes of action.

That these agents inhibit the formation of glucose from fructose and other sugars by the liver has been rather conclusively demonstrated in several laboratories[4]. This does not necessarily explain its clinical effects, although it is reasonable to assume that it has some importance. This action is not the only means of lowering the blood sugar, for these agents are still hypoglycemic in hepatectomized animals[8]. A mechanism of interference with the formation of glucose (gluconeogenesis) has not been established.

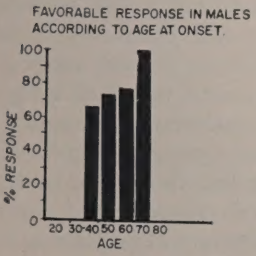
It has also been shown that tolbutamide interferes with one of the enzymes necessary for the conversion of glycogen to glucose (Glucose - 6 - Phosphatase) in vitro, but only in large doses[9]. Other agents which have been shown to have a similar effect on Glucose-6-Phosphatase have not been shown to have a similar blood sugar lowering effect.

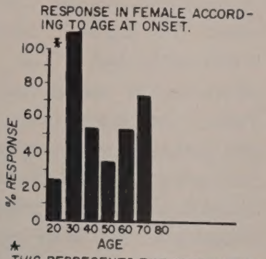
A substance elaborated in the alpha cells of the pancreas having a marked blood sugar raising effect has been identified. This substance has been called glucagon or the hyperglycemic factor and acts by speeding the breakdown of glycogen in the liver. The role of glucagon in diabetes is still obscure. Most people think that it has little importance in the pathogenesis of this disease. Nevertheless, there is no direct assay of this substance, and there is the possibility that this substance may be of significance in clinical diabetes.

It is distinctly possible that the oral hypoglycemic agents exert their effect by inhibiting the hyperglycemic factor. It has, however, been shown that the effect of exogenously administered glucagon is not affected by Orinase.[5] This still does not eliminate the possibility that endogenous production is inhibited. While not submittable to direct proof at present this must remain as a possible means of action. It also has the merit of explaining the need for the presence of functioning islet cell tissue. Morphologic changes of the alpha cells after the administration of Orinase have been inconstant in appearance and difficult to interpret.

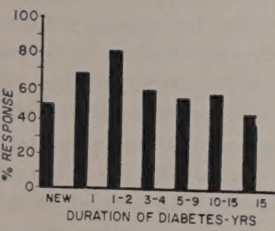
The role played by the adrenal cortical hormones, somatotrophic hormone, and thyroid hormone in clinical diabetes is a subtle and at best a permissive one, except in the rather uncommon cases of steroid diabetes or acromegaly. Certainly in the vast majority of diabetics the role of these substances is minor in terms of pathogenesis. The possibility remains that the hypoglycemic substances exert a portion of their effect by inhibiting the action of one or several of these hormones. A mild and temporary antithyroid effect has been demonstrated after the use of tolbutamide. However, no instance of functional hypothyroidism or the development of goiter after the use of tolbutamide has been reported. The antithyroid effects, however, would not explain the prompt hypoglycemic effect.

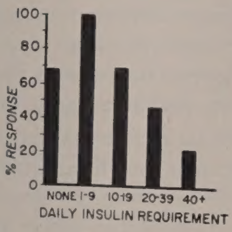
Studies of the effect of these drugs in adrenalectomized or hypophysectomized animals have been performed. When these animals were completely pancreatectomized in addition to being hypophysectomized or adrenalectomized there was no blood sugar lowering effect, again demonstrating the primary importance of the pancreas. In dogs with an intact pancreas but without adrenals or pituitary glands the effect of the oral hypoglycemic agents was enhanced compared to the intact animals. However, the hypoglycemic effect is much more pronounced in the adrenalectomized as compared to the hypophysectomized animals. That there was this difference between the two groups is evidence that the mode of action is not by adrenal or pituitary inhibition or the two groups should have behaved in a similar fashion. Many other fragments of information are available but do not really clarify the picture significantly. Regardless of the mode of action of these drugs they do have undoubted blood sugar lowering effects in a number of diabetic patients. Our results in 138 cases as to age at onset, duration of diabetes, and insulin requirements are summarized below:


FAVORABLE RESPONSE IN MALES ACCORDING TO AGE AT ONSET.


RESPONSE IN FEMALE ACCORDING TO AGE AT ONSET.

★ THIS REPRESENTS THE RESPONSE IN 2 OUT OF A TOTAL OF 2 PATIENTS.





Clinical Evaluation

Even though the relatively small number of patients in our group does not lend itself to statistical analysis, certain trends are apparent. In our series an adequate response in the obese and well nourished group was approximately 60 per cent, but only about 30 per cent in the poorly nourished group responded.

In general, it may be said that the shorter the duration of diabetes, the older the age at onset, and the smaller the insulin requirement the better the chances of any one individual responding to the action of these drugs. Many clinical evaluations have corroborated these facts. However, in any single person these facts are of only limited predictive value, for even in the relatively younger age groups with high insulin requirements an occasional response is seen.

Discussion

The level of hypoglycemia resulting from a single dose of tolbutamide has been used as a screening test for the ability to respond to prolonged therapy, but experience generally has shown this to be an unreliable guide[10]. It is our feeling that a clinical trial of drug therapy is the only effective way of determining those patients who will have a response. We do not attempt a trial of therapy in juvenile diabetics, or in older persons whose diabetes is brittle with a tendency toward rapid onset of acidosis. But in the bulk of older, more stable diabetics, we feel that a trial of therapy is indicated. If no appreciable blood sugar lowering effect has occurred by three days the test is considered a treatment failure. Occasionally an equivocal response at this time warrants a more protracted trial, and we have seen a slow, prolonged, gradual diminution of blood sugar over a six week period in one patient with no appreciable change in diet as reflected by a stable weight.

Our usual dosage schedule has been a loading dose of one gram, three times daily, for one or two days, and then a maintenance dose of between .5 to 2 grams daily, usually given in divided doses. The maintenance dose will depend on the patient's response.

Toxicity with tolbutamide has been negligible. Reported incidence of minor side reactions has been about 2 per cent, most of these being transient dermatologic problems. No instance of serious, hematologic, hepatic, or renal disturbance has been reported in human beings. Crystalluria has not been a problem.

Fewer episodes of hypoglycemia occur than with insulin and this represents an advantage in therapy, particularly in the more elderly group with associated cardiovascular disease where the dangers of hypoglycemia are significant.

Since the urinary metabolite of tolbutamide is precipitated by acid, false positive tests for urinary protein are obtained if the reagent used to test for protein is an acid precipitant such as sulfosalicylic acid. It is recommended that positive tests for urinary protein be confirmed by heat or the recently developed Albutest®.

The ultimate role of these interesting drugs in the treatment of diabetes is yet to be established. At the moment of writing, these drugs have been found to be useful in a large group of diabetics and represents a significant advance as far as patient comfort and convenience are concerned. They are however, of no use whatsoever in the treatment of diabetic acidosis, and do not lend themselves to the control of a diabetic through such complications as surgery or severe infection. Nevertheless, patient enthusiasm for this drug has been very great indeed. Although only an impression, it is our feeling, based on spontaneous remarks of the patient, that there is a feeling of well being that is not present with the use of insulin. Whether this is due to the fact that they no longer have to go through the painful ritual of insulin administration, or to the fact that they are receiving a new, widely publicized drug, or whether this is a true drug effect is not known.

The possibility exists that these drugs may by nature of their effect on the beta cells of the pancreas, eventually cause their exhaustion. Clinical evidence to date, however, has not demonstrated this. Its long term use in a large number of patients without deterioration of diabetic status seems to controvert this notion. Also, patients who for unknown reasons, lose their response to Orinase after several months are generally satisfactorily controlled on their former dose of insulin.

Other oral hypoglycemic agents are being investigated, and may prove to have significant advantages over the presently available drugs. Such an agent is N^1-B-phenethylformadinyliminourea, also designated as DBI or PFU. Preliminary studies have shown that the drug is active in some patients who do not respond to tolbutamide. The clinical evaluation of this drug is now being undertaken at several centers and its advantages and disadvantages should shortly be known.

Summary

A brief history of the development of hypoglycemic agents has been given, along with a presentation of the salient features of mechanism. A resumé of the clinical evaluation is presented.

Conclusions

Although the mode of action of the arylsulfonurea drugs is still not established, the drug is a useful hypoglycemic agent in the majority of adult, stable diabetics and has little significant toxicity.

Acknowledgments: Grateful acknowledgment must be given to Dr. C. J. O'Donovan and The Upjohn Company for liberal supplies of tolbutamide and financial assistance. We are also grateful to the Comly Coleman Fund of the Ohio State University and the National Institutes of Health, Division of Arthritis and Metabolism, for their financial aid.

Addenum: Since this article was written our experience encompasses the treatment of 258 patients as of May 1, 1958. This added experience merely confirms the impressions and statements made in the article presented.

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Proper Choice of Tranquilizer

One thing I have noticed is a tendency to use whatever tranquilizer happens to be in vogue at the moment, rather than to prescribe on the basis of the patient's needs. Just as with other medications, these drugs have to be tailored to suit the individual.—Ralph Burbridge, M. D., Erie, Pa.: *Pennsylvania M. J.*, 61:999, August, 1958.

Medical and Surgical Management Of Bronchiectasis

It is important to realize that bronchiectasis is a serious disease and that once a lobe or segment has become fibrotic and contracted it is irrevocably lost. The treatment is both medical and surgical and is based on the extent of symptoms. Surgery is done if symptoms are of sufficient severity, if bronchiectatic changes are proved and adequately localized by bronchographic study, if cardio-respiratory reserve is adequate and if no other severe disease is present. Management is conservative when the disease is so slight that surgery seems unnecessary or so extensive that pulmonary resection cannot be considered. Conservative measures may be employed as a means of preparing patients for definitive surgery and in other instances as an ultimate form of treatment.

Some patients can be improved by active postural drainage, breathing exercises and the use of penicillin inhalations. Antibiotics have proved to be of considerable value in the therapeutic management. A period in the hospital under the active supervision of the physician and nurses will teach the patient the correct methods of postural drainage and of breathing.

The mortality of pulmonary resection in its various forms, even including bilateral cases and the complicated cases in all age groups, has decreased steadily in the past two decades until it has now reached levels that are gratifyingly lower than those for most comparable major surgical procedures. The hospital mortality is in the neighborhood of 1 to 2 per cent or less. It is of importance to note that the general condition of the patient and the extent of the disease are of far more significance than age.

Surgical management in children as in adults is an individual problem, but if possible, the operation should be at an age when reasonable cooperation may be expected, probably between the ages of 6 and 12.

It is well to remember that bronchiectasis is a dangerous disease and for the most part is associated with moderate to severe disability. There is usually a period of years of ill health. It is the opinion of most of those treating this disease that in the absence of contraindications of a formidable nature, resection therapy is the treatment of choice as it offers the best probability of permanent relief of symptoms. Segmental resection is used to its greatest advantage in the treatment of this disease as it increases the possibilities of bilateral excision.—Porter Mayo, M. D., Lexington, Ky.: *J. Kentucky State M. A.*, 56:865, September, 1958.

The Effects of Orinase® in Clinical Diabetes

CAROL E. CRAIG, M.D., JAMES L. CALVIN, M.D.,
and E. R. McNEAL, M.D.

SINCE the isolation of insulin in 1922, attempts have been made to find an effective, oral hypoglycemic drug. Many such agents have been tried only to be discarded because of their ineffectiveness or toxicity[6]. In 1942, Janbon was working with a sulfonamide preparation for typhoid fever. He accidently discovered that this agent had hypoglycemic properties. Since that time different sulfonylurea compounds have been studied. Orinase is one of these hypoglycemic drugs. It is the purpose of this paper to present our results with the clinical use of Orinase in 30 diabetic patients.

Of the 30 patients included in this study there were nine males and 21 females. The patients were studied from July, 1956, to September, 1957. Twenty-six were hospitalized and four were treated solely as outpatients. No regard was made as to the patient's age, weight, duration of diabetes, previous mode of treatment, severity of diabetes, or other pathologic states related or unrelated to diabetes. All we required was that the patients had diabetes mellitus.

No preliminary screening tests were done to help predict the final outcome of success or failure. Patients were placed on diabetic diets according to their caloric needs. Routine and periodic laboratory studies included a complete blood count, platelet count, urinalysis and liver function studies. Twenty-four hour quantitative urines were obtained until the urine was free of sugar, or until the trial was considered a failure. Blood sugars were obtained in the fasting and postprandial states.

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- **Dr. Calvin, Youngstown, is physician, Department of Medicine; director of Graduate Training in Internal Medicine, and consultant in Cardiology Clinic, Youngstown Hospital Association.**
- **Dr. McNeal, Youngstown, is physician, Department of Medicine, and consultant in Cardiology Clinic, Youngstown Hospital Association.**

TABLE 1.—*Relationship of Age at Onset of Diabetes and Number of Patients Controlled.*

Age in Years at Onset of Diabetes	Number of Patients in Each Age Group	Patients Controlled	
		Number	%
Below 20	1	0	0
20 — 29.9	1	0	0
30 — 39.9	2	0	0
40 — 49.9	9	5	55.5
50 — 59.9	6	3	50
60 — 69.9	6	6	100
70 — 79.9	5	5	100
Totals	30	19	63.3

TABLE 2.—*Relationship of Body Type to Number of Patients Controlled on Orinase.*

Body Type	Total No. of Patients	Patients Controlled	
		Number	%
Asthenic	6	3	50
Medium	14	9	64.3
Heavy	10	7	70

The patients who were on long acting insulin were continued on that therapy until the day the Orinase was started. The insulin was then abruptly stopped. The usual starting dose of Orinase was 3 grams the first day followed by 2 grams the next day, with subsequent dosage adjusted to the blood sugar levels. Diabetic control was considered successful with a significant drop in the blood sugar levels, no glucosuria, control of diabetic symptoms, and no untoward reaction to the Orinase.

Table 1 shows the relationship of age at onset of diabetes and number of patients controlled. There were 19 successes, or we had an overall control rate of 63.3 per cent. We had one patient below 20 years of age who was a failure on Orinase. As the age of onset of diabetes increased the number of patients controlled increased, and in the 11 patients who were 60 years and older we had 100 per cent control. This finding is consistent with other studies[3,4,5,7,8] that is, it is the older diabetic who is most likely to be successfully controlled with Orinase.

Much has been written about the obese diabetic and control with the sulfonlyurea drugs[3,5]. Table 2 shows the relationship of body type to number of patients controlled on Orinase. In many studies the obese diabetic had a distinct advantage. This was not as apparent in this series, as three of six or 50 per cent of the asthenic patients were controlled. In the heavy group, seven of the 10 were controlled indicating that obesity, while it does play a role should not be a deciding factor as to whether or not to try Orinase.

We had a total of 11 failures. Of these four had the juvenile type of diabetes, three had allergic reactions to the drug, and one had chronic pancreatitis. Eight of the 11 failures had previous ketosis. Ketosis occurred in all age groups from below 20 to 60 years. We had no instance of success in patients with a previous history of severe ketosis and acidosis. This would suggest that previous ketosis is a contraindication to successful control of diabetes with Orinase.

Table 3 shows the relationship between previous mode of therapy and subsequent successful control on Orinase. The first column shows the previous dose of insulin, the middle column the number of patients in the group, and the last column the number of patients controlled. The patient with over 80 units of insulin was not controlled. The four patients with 60 to 80 units also were not controlled. Of the five patients who were taking 40 to 60 units two were controlled and of those taking less than 40 units, all were controlled.

TABLE 3.—*Relationship Between Previous Mode of Therapy and Subsequent Successful Control on Orinase.*

Previous Insulin Dose in Units	Number of Patients	Patients Controlled	
		Number	%
Over 80	1	0	0
60 — 79.9	4	0	0
40 — 59.9	5	2	40
20 — 39.9	2	2	100
Below 20	6	6	100
Totals	18	10	55.5
No Previous Insulin Therapy	12	9	75

There were 12 patients who had had no previous insulin therapy. Of these nine were controlled. Of the patients with previous insulin therapy, 55.5 per cent were controlled while 75 per cent of the patients without previous insulin therapy were controlled. As in other series$^{3, 4, 5, 7, 8}$, Orinase was most successful in patients who had had no previous insulin therapy or in those in whom the previous insulin dosage had been low.

We did have three drug reactions. The first of these was that of fever, nausea, vomiting and lethargy which cleared after the drug was stopped. Three months later this patient was again given Orinase and although there was no fever—nausea, lethargy and generalized body aches developed. The second was that of urticaria in a patient who had previously reacted in a similar manner to Gantrisin®. This also subsided when the Orinase was discontinued. The third was that of a papular eruption, primarily of the face, that developed in the ninth month of treatment. This also cleared when the Orinase was stopped.

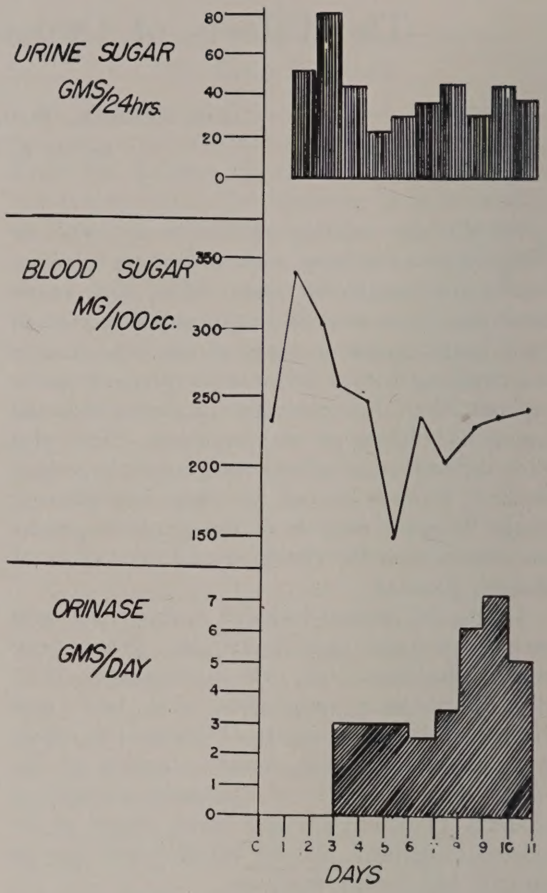

FIG. 1. Clinical course of a patient who was a failure on Orinase.

Some examples of the successes and failures follow. Figure 1 is a chart showing the clinical course of one of the failures. This patient was a 41 year old white male not on previous insulin. Before Orinase therapy he had blood sugars between 235 and 340 mg. per 100 cc. and was spilling up to 80 grams of glucose per day in the urine. Orinase was given in three gram doses for three days and on one day the blood sugars dropped to as low as 150 mg. per 100 cc. However, following this, and despite high doses of Orinase up to 7 grams a day, the blood sugars rose and remained above 230 mg. The glucosuria continued. This man was a failure on Orinase and was subsequently controlled on insulin.

Figure 2 is a chart from the record of a 66 year old white male. He had not taken insulin and had never been on a planned diet. He was treated as an outpatient. His initial blood sugars were about 430 mg. per 100 cc. He was placed on a diabetic diet for about three weeks. His blood sugars dropped to about 225 mg. He was started on 3 grams of Orinase with gradual reduction of the dosage. His blood sugars were reduced to a low of between 108 and 120 mg. It was decided to try him without Orinase for four days to see what the blood sugars would do on diet alone. This was done and his blood sugars again rose to around 225 mg. Orinase was started again with a return of blood sugars to below 140 mg. indicating successful control on Orinase.

Figure 3 shows a long term successful control on Orinase. This patient is a 63 year old white male who had previously been treated with insulin without good control. He had received from 40 to 50 units of insulin per day. Blood sugars ranged in the high 200's. Orinase was started on the patient in the hospital. He was continued on 1½ grams of Orinase per day, later dropped to 1 gram per day and, following his course over a nine month period, all of his blood sugars are in the range of 125 mg. per 100 cc. with no glucosuria. He had excellent control on Orinase. However, after nine months of treatment, Orinase was discontinued because of a skin reaction. Again he is only fairly well controlled on NPH insulin.

Summary

In summary, the clinical response of 30 diabetic patients to Orinase was tested. Nineteen or 63.3 per cent were controlled on Orinase. Patients who were most easily controlled were elderly diabetics, those who had had no previous insulin therapy, or those who had received less than 40 units of insulin per day. Patients who did not respond were the juvenile diabetics or those who had a previous history of ketosis. The heavy type individual had a slight advantage; however, 50 per cent of the asthenic type and 64.3 per cent of the normal weight individuals did respond. Three allergic reactions did occur.

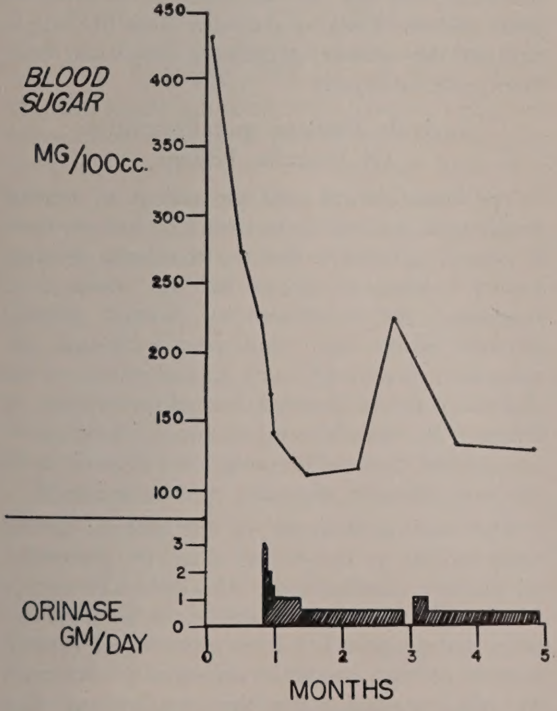

FIG. 2. Clinical course of a patient not previously treated with insulin showing successful control on Orinase.

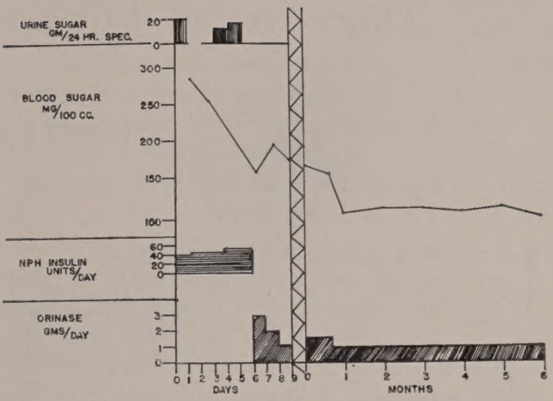

FIG. 3. Clinical course of a patient previously treated with insulin and subsequently controlled on Orinase.

Time will determine what the future role of Orinase will be in the treatment of diabetes mellitus. It should be emphasized that Orinase is not a substitute for insulin therapy. Many clinicians feel that all diabetics should be taught how to use insulin, as it is a well known fact that Orinase is not effective in times of infection, trauma, surgery or any stress situation[1, 2, 3]. However, on the basis of the experience in this series of patients, it would appear that Orinase is a convenient and successful method of treatment for the older, mild, adult-type diabetic patient.

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Objectives of Effective Diabetic Management

JOSEPH I. GOODMAN, M.D.

IT is now 37 years since insulin was introduced as a specific drug for diabetes mellitus. This epochal contribution has resulted in a longer life for many diabetics, but also has caused unforeseen difficulties and misunderstandings for the medical profession. A mist of confusion about insulin therapy has slowly arisen and so far has shown little evidence of clearing. A practitioner, caught in the morass of disagreement, becomes increasingly befuddled.

Once the diagnosis has been established the physician must provide himself with a thorough history and physical examination in order to treat not only the diabetes but any associated disorder. First and most important is a search for any evidence of ocular involvement. Does the patient complain of pain or paresthesia suggestive of diabetic neuropathy? Are there indications of vascular impairment or ulceration of the lower extremities? Albuminuria may denote intercapillary glomerulosclerosis. The presence or absence of these stigmata will help us to determine whether the diabetes is of recent origin or long standing.

The therapy of diabetes is not simple, but too often medical writings on this subject make it appear more complex than necessary in the light of present-day knowledge. Details of therapy are too frequently maintained at the research level instead of being reduced to those essentials necessary for clinical application.

Objectives of Diabetic Control

What constitutes control of diabetes? Of course the ideal objective would be restoration of the individual to normal. Since diabetes is incurable few, if any, patients attain this goal. In actual practice one seeks to provide a regimen which brings about optimal regulation and minimal interference with normal living habits. The objectives are: 1. Relief of symptoms and maintenance of physical and mental well-being; 2. achievement and maintenance of normal weight; 3. prevention, postponement or minimization of complications. The necessity of avoiding keto-acidosis and insulin reactions is acknowledged by all and, since they are largely preventable, their occurrence is for the most part inexcusable. The relief of symptoms and maintenance of normal weight are objectives which can be easily realized in cooperative patients by the appropriate use of diet, Orinase® and insulin. In most cases the relief of symptoms is accomplished so easily as to be hazardous. One should aim to help a patient remain active and useful in his or her community endeavors.

The Author

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The first step in the treatment of diabetes is not any particular diet or kind of insulin but the emphasis on *control*. Too many people abhor the word discipline but it is this which makes for the successful treatment of diabetes and represents the foundation of that morale which is observed in great soldiers. There is always a cause of failure; perhaps the patient, family or physician, self-indulgence or neglect.

Juvenile Diabetes and Prevention Of Vascular Lesions

The diabetic child need not present an unusual problem. Regardless of the school of therapy, there is general agreement that the standards of satisfactory treatment should be the absence of symptoms, the attainment of normal growth, physical health and wholesome emotional development. Moreover, sound clinical control of the diabetic child is directed toward preventing or delaying the vascular complications of long standing diabetes. Successful management depends upon the joint efforts of physician, parents, and child.

The modern treatment of the diabetic patient must include as its primary goal the prevention of vascular complications. Although achievement of this success is not immediately at hand, it appears that progress lies in the direction of optimal control of the metabolic abnormality. Frederick M. Allen maintains that the complications of a diabetic are uniformly preventable and, if present, may generally be arrested by vigorous control.

What is the dividing line between satisfactory metabolic balance and the early defections which if not controlled would lead to complications? The answer to this question is important. With an increasing number of children and adolescents, there will of course be an increasing number of young people with diabetes. One hopes to protect them not only from diabetic coma and other acute complications, but also from the disasters of complications of the nervous and vascular systems some 15, 20, or 25 years hence.

Management of the Ambulatory Diabetic Patient

Until recently the hospital was generally believed to be the best place for the initial treatment and instruction of the patient with even uncomplicated diabetes. In the past, hospitalization of patients with newly discovered diabetes was deemed essential primarily for two reasons: dietetic training, which most physicians are not prepared to give in necessary detail, and instruction in the use of insulin. Today, a number of circumstances have combined to make it a less desirable place than the doctor's office for the purpose.

The shortage and expense of hospital beds constitute a deterrent to hospitalization. For persons without hospitalization insurance the cost of board and room alone has risen to unprecedented heights. On the other hand, the very success of the insurance program has resulted in the filling of hospital beds almost to capacity, so that patients often must wait to be accommodated. When they are finally admitted, the chronic shortage of nurses, and recently of interns, is a discouraging obstacle to proper care and training. Even if a patient is willing to stay in the hospital, his regimen must be altered in the direction of increased calories or decreased insulin dosage or both when he returns to his usual activities. Finally, in most hospitals the principal meals of the day are telescoped into the brief period between 8:00 and 8:30 a.m. and 4:30 or 5:00 p.m., so that the timing of insulin action in relation to food intake is quite different from that which obtains on the patient's customary schedule.

While there will always be some patients who should be hospitalized, the majority can be managed with complete satisfaction in a well equipped office or outpatient department. Such management, if it is to be successful, must include the instruction of the patient as one of its major aims. This requires of the physician the willingness to teach and the time and patience to do it. Actually both dietetic training and instruction in the use of insulin can be given readily by the doctor in his own office or in the clinic setting. With the increasing shortage of hospital beds and increased expense to a patient more and more people will find it necessary to seek outpatient or office care. If the patient can continue to work while his diabetes is being controlled the cost is reduced, and, more important, he is assured that his condition can be controlled by his own physician.

Education of the Diabetic Patient

Diabetes is a lifelong condition which demands more participation by the patient in his own care than any other disorder. All diabetic patients should be taught as much about their condition as their capabilities for learning will permit. A physician who accepts the diabetic as a patient assumes the trust and responsibility of giving that patient the advantages of all the factual information amassed over the years. Furthermore, he should assume from the outset that the patient will be dependent upon him for such advice as will enable him to enjoy maximum health over a period of years.

While the value of patient education has never been questioned, the degree of success achieved currently has been. Those dealing extensively with diabetic patients find that both new and old patients are equally in need of education and constant re-education. Both groups have their share of misconceptions about the disease. It is therefore fallacious to assume that a diabetic, however long his course, has been properly indoctrinated. Moreover, the elderly diabetic who is extremely forgetful constitutes the largest group to be taught and a great challenge. Children are no exception. In the case of younger children, it is of vital importance that the parents be thoroughly familiar with the basic facts regarding the nature, treatment, and possible complications of diabetes. Every opportunity must be taken, either individually or in classes, to instruct patients and their families.

Education does not consist simply in presenting the basic facts of diabetes to patients. Rather, it should be directed to a real understanding of the disorder and a proper attitude toward its management. Does the patient understand the causes of acidosis? Does he know what to do if he has taken insulin and cannot eat, or whether to take insulin if illness prevents his eating? Has he been adequately indoctrinated in the care of the feet? Adequate instruction by physicians, nurses, and dietitians is most important. This can be accomplished efficaciously for large groups in outpatient departments. Finally, the patient should be given definite written instructions dealing with diet, foot care, insulin instruction, and the hazards of self-surgery and self-medication should be clearly underlined. The potential seriousness of diabetic complications should be presented in their proper perspective.

At the initial visit, the patient is requested to continue his previous food practices and record them, to take insulin, if any, as before. Every new patient should be given dietary and insulin instructions in the first week of treatment. Encouragement and optimism is a primary part of such treatment. At the second visit the patient brings his food diary, insulin equipment and a 24-hour specimen of urine for quantitative analysis. Regular visits to the physician are important in maintaining satisfactory control.

Moral Support

On first learning of his diagnosis the diabetic patient is besieged with many fears. He worries about the effect of the illness on his future activities and employment. He has already heard of insulin and usually dreads the thought of needles. He has visions of severely restricted diets and fears the loss of eating pleasures. To the patient the immediate picture is one of gloom and a lifetime of drudgery. With some patients, the terms "diabetic gangrene," "insulin shock," and "death" strike a familiar note. Later the diabetic is struggling daily with an unnatural regimen of prescribed meals and hypodermic injections, and the tendency to grow careless and take liberties with the diet increases as time goes on. Parental attitudes are extremely important in the management of childhood diabetes. They can vary from the overly permissive to the overly restrictive. Overanxious parents may create an overanxious child, and the result may be psychologic invalidism or—quite the reverse—defiant revolution. Indulgent parents may be exploited by the child, whereas perfectionist parents may transform their child into a "diabetic robot."

In the past we have failed to capture the interest and enthusiasm of the diabetic patient for continual and lifelong self-care. There has been overemphasis on giving the patients purely medical facts, and not enough attention to promoting proper psychologic attitudes toward their condition. Psychologically, any shock caused by emphasizing the permanency of diabetes and diabetic adherence can be cushioned by citing reassuring statistics on the longevity of diabetics. Diabetes has been changed from a metabolic *disease,* incapacitating and progressing slowly or more rapidly to an inevitable end, to a metabolic *defect* and this defect is controllable by suitable, though different, diets and the skillful application of insulin, thus enabling the patient to live long, happy, and useful lives. The physician can use these weapons to strengthen his patient's morale, and to make his patient see that science has discovered a way to train him to win the game.

Generally speaking, the physician who is aware of the emotional needs of the diabetic child and the parental adjustments required should be capable of dealing with most of the problems. It is the physician's responsibility to plan a course which will bring about optimal growth and development and as normal a life as possible. With the full cooperation of parent and child this can in most instances be achieved.

The family physician therefore becomes an important buffer in allaying the patient's unhappiness and fears. He must reassure the patient that dietary restrictions will be neither unreasonable nor severe. He must explain to the patient that the daily administration of insulin will become a routine to him, no worse than his daily ablutions. The fear of insulin shock and gangrene can be allayed by explaining that they occur only in the poorly regulated patient and that these dangers will be obviated by the regime upon which he is to embark. These explanations and reassurances must be repeated on subsequent visits, because the diabetic is usually so stunned on his first visit that he retains very little of what is told him.

In summary, a physician should seek to further the patient's welfare by sympathetic understanding of his psychologic welfare, as well as the immediate complaint. It is his duty to give the patient an objective—a definite task to perform that will stimulate hope and peace of mind. One such objective may be to inspire the diabetic to strict adherence to his daily routine in order thereby to compete with the nondiabetic for longevity. A patient who consults his doctor regularly, improves his prognosis. It is just as important for him to see his physician regularly as it is for some people to go to church every Sunday, and, in part, for somewhat analogous reasons.

Role of Diet in Diabetes Mellitus

The ideal caloric allowance is one that over an extended period will maintain body weight or rate of growth at the level most conducive to well-being. The patient's weight is a vital measuring stick, because it is only in relation to his immediate weight status that we can intelligently select a diet. The attainment and maintenance of normal body weight are not difficult in cooperative patients.

Most obese diabetics do not need insulin for the control of the diabetes provided proper attention is paid solely to their obesity. A return to normal weight often parallels the complete disappearance of glycosuria and hyperglycemia, or at least a marked amelioration of the diabetic state. The underweight diabetic must be given a diet which will permit him to gain even if it means 3000 to 4000 calories per day; glycosuria can be controlled with insulin. The major goals in the dietetic management of the juvenile diabetic are to: (1) Meet the nutritional needs for growth and development; (2) keep the food intake relatively constant in amount from day to day; (3) adjust the diet as far as possible to the family meal patterns and personality of the patient, recognizing that practicality and flexibility assures a greater degree of cooperation.

In general, *when a diet designed to correct abnormal body weight or maintain normal body weight fails to render the urine sugar free, the use of Orinase or insulin is indicated.*

Hyperglycemia and Glycosuria

Any plea for good diabetic control should state what is meant by the term, how often it is attained in practice, and what is the method of producing it. The most common method in use for evaluating the dosage of insulin is examination of the morning urine specimen for sugar and an occasional fasting blood sugar. As John points out[1] one can never procure enough data from the blood sugar level in any one 24-hour period to provide a clear picture of the patient's course and his changing needs for insulin. This author presents some interesting case histories to illustrate how misleading an occasional, random blood sugar determination can be, as well as an isolated fasting blood sugar. Moreover, the blood sugar data represents the condition only at the very moment the blood is drawn, a figure which may have been vastly different a few minutes earlier or later, or even at the same hour on another day. Perhaps the most important thing one can say of the blood sugar value is that it must not be overinterpreted. I resort to blood sugar determinations only occasionally to check on a possible hypoglycemia and for glucose tolerance tests.

Data on urine sugar, when expressed as 1-4 plus, are far from quantitative, since 4 plus sugar may represent concentrations varying from 1.5 all the way to 6-10 per cent[2]. Spot urine tests are valueless as in the case of the blood sugar. As a matter of fact, they usually are misleading. The second thing to consider is the fact that a concentrated urine specimen of small volume may show considerable sugar qualitatively; on the other hand, a dilute large volume specimen may show only a faint trace or a trace qualitative reaction when, in fact, the actual amount of sugar in both specimens proves to be identical. The author gauges the efficacy of the treatment by means of quantitative determinations of the urine sugar carried out for the entire 24 hours and tested by the method of Somogyi[3].

The quantitative glucose content, as determined in total 24-hour urine specimens, provides an objective criterion which is useful in evaluation of the degree of control of the individual. Estimation of the 24-hour, quantitative urine sugar is of considerable value, in that it indicates the exact amount of glucose excretion which, in turn, tells us what proportion of his carbohydrate intake is utilized. A maximum excretion of 10 grams of glucose is acceptable to most authors. If more than 10 grams of urine glucose per 24 hours is excreted a change in the regimen is indicated. Moreover, this seems to be a practical standard whereby the systems of management practiced in different centers can be compared.

The use of a graphic chart is extremely valuable in the management of diabetic patients. As is the case with a temperature graph depicting typhoid fever, pneumonia, etc., one can comprehend the picture at a glance. On this chart one records the quantitative sugar data, insulin dosage, weight, and dietary data at each visit. On subsequent visits one can quickly size up the situation and correlate the immediate findings with previous data frequently going back many years. I have maintained such graphic records for over 12 years and find them well worth the extra effort, for the control of diabetes is a systematic, rational procedure.

What Is "Mild" Diabetes?

The type of diabetes most frequently mistreated is the common variety seen in the middle-aged and older obese groups of patients. Fully one half of all of the two million or so diabetics in this country fall into this category. In them the diabetic state either escapes detection or is labelled "mild" simply because symptoms are absent, or because insulin requirements are low. Most of them are mismanaged, due to indifference either on the part of the patient, his doctor or both. Little attention is paid to the diabetes until complications appear and then it is too late.

A woman described by McLaughlin and Bradley[4] illustrates the point vividly. Only a few years after learning of her condition the "mild" diabetes became associated with neuropathy, retinopathy, occlusion of an axillary artery, myocardial damage by electrocardiography and, finally, cerebral artery thrombosis. It is so mild, that like minimal tuberculosis or malignancy, more is to be gained by meticulous care than after it has progressed in severity irreversibly. In spite of increasing indications that haphazard treatment is harmful there are still many who accept it complacently. This leads to the paradox that only a small fraction of patients are well regulated, even though 80 to 90 per cent could be.

Diabetes is diagnosed in the majority of patients by casually discovered glycosuria. Many physicians still have difficulty in accepting the concept that this asymptomatic stage of diabetes is an early phase of a disorder, even though they have been conditioned to do so in diseases such as leukemia, cancer, and others. Consequently the majority of patients too frequently receive a half-hearted diagnosis couched in vague terms such as "sugar in the urine or blood"; often even the use of the term diabetes is omitted. Little wonder that these patients entertain doubts regarding the reality or significance of their condition. After the laboratory findings have been normalized by therapy, some patients may be erroneously told that the diabetes has been cured or never existed. The patient is only too willing to grasp at this straw and may disappear from medical purview. Subsequently, the disease or its complications is likely to return them to the fold much the worse for the experience.

Contrasted with the clinical picture before the discovery of insulin, the institution of insulin *seems* to solve most of the immediate problems of the mild diabetic. First, insulin keeps most diabetic patients alive and feeling well even in the presence of persistent glycosuria and hyperglycemia. Symptoms, if present, are usually diminished or eliminated, weight is maintained, acidosis is easily avoided, as a rule. Second, an ad lib diet, with enough insulin to control symptoms, is an easier method of treatment than one which demands a rigid chemical balance. An improperly briefed patient is more prone to misinterpret the allowable freedom of food exchanges as a license to make unphysiologic shifts in food. Little knowledge or determination are required to take insulin, eat according to one's whims and ignore blood or urine sugar tests.

After several years of poor regulation, certain mental and personality changes are observed in diabetics of all ages which tend to make them forgetful, stubborn and opinionated. Two major difficulties then ensue: (1) the discrepancy between the problem of self-care and the capability of the patients increases and, (2) due to poor judgment, the division of authority between doctor and patient becomes increasingly hazy in the latter's mind.

Too often the patient's indifference is caused by his medical advisor's attitude. As previously mentioned, the diagnosis and prognosis of diabetes are not explained to a large proportion of patients convincingly enough at the onset of the disease. The physician who condones freedom of action usually meets with the patient's favor for prescribing an easy, convenient method which is just what he wants.

The type of diabetes under discussion is the easiest to balance perfectly and, in the author's opinion, the most important kind to treat this way. These cases respond beautifully to a little effort, knowledge, and a conviction that something is to be gained by doing so. Perfect control of these patients can be achieved by intelligent planning of the diets, loss of excess weight, the daily use of Orinase in some cases and of small doses of insulin in others, and frequent quantitative urine tests to guide the course.

First, it is necessary to expose the fallacy that a chronically poorly regulated diabetes necessarily reflects itself in subjective symptoms or in a fasting (rather than two-hour postprandial) blood or urine test. Food intake must be constant from day to day until it is known to be constant and uniform. There must be proper appreciation of the timing qualities of the various insulin preparations and selection of the one most suitable for the individual behavior as seen in the fractional urine results. Discipline and consistency of habit are the chief reasons for successful results. For all we now know perfect regulation prevents many complications and may postpone vascular lesions indefinitely. Actually both physician and patient profit by the knowledge that insulin reactions are avoidable by scrupulous attention to the details of diet and insulin administration.

It is my firm belief that another generation of diabetics managed according to these principles will tell a different story about the inevitability of diabetic complications. The only reason that this fact is not demonstrable now is due to the failure of regulation in too many patients and lack of encouragement to do so on the part of many doctors. If this concept is valid, here is an opportunity to practice preventive medicine in its purest form. We have the means to keep diabetics alive; now we must learn how to keep them well.

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Some Interesting Observations in Diabetes Mellitus

HENRY J. JOHN, M. D.

I AM presenting some observations on diabetes in 10 cases, each of which presents some interesting observations which happen in everyday practice.

Case 1. A boy, 9 years old when I first saw him on October 2, 1936, at which time his blood sugar at 3 p.m. was 42 mg. per 100 ml. at which time he had been on diet alone for a while. Only two days later, the blood sugar, at 3 p.m. when he was on the same diet was 341 mg. per 100 ml. Thus he was put on insulin, 10-10-10 a day. By December 29 at which time the insulin was reduced to 7-0-7 units a day, his blood sugars, taken three times daily, before meals, were: 57-36-87 mg. per 100 ml. and thus the insulin was reduced to 8-0-0 units, taken after breakfast.

Even on this small dosage, on February 22, 1937, his blood sugars on 8-0-0 were: 46-37-53. Thus the dosage was reduced to 6-0-0 and taken after breakfast. At that time he was on a diet of 180 Gm. carbohydrate, 80 Gm. protein, 128 Gm. fat, a total of 2100 calories. His weight rose from the original 53 pounds to 62 pounds. He became careless then with his diet and the insulin had to be raised to 60-0-0 units of protamine zinc insulin.

In 1948 he was in diabetic coma on February 5 so that when he was brought out of coma he had to take 80-0-0 units of protamine zinc insulin a day when his blood sugars were: 95-65-143. On November 23, 1954, at which time he was 27 years old, he showed retinal hemorrhages and was taking 35-0-0 protamine zinc insulin a day and the blood sugars were: 47-125-184 mg. per 100 ml. Then I lost track of him and he was married in the meantime. He died on September 13, 1955 at Mt. Sinai Hospital where he was taken in severe coma and was taken care of by the hospital staff.

At autopsy the section showed the following:

1. Diabetes mellitus: a. Hypogenesis of the islets of Langerhans.
2. Acute pancreatitis.
3. Hypertophy of the heart (weight 450 grams).
4. Passive hyperemia of viscera.
5. Pulmonary edema.
6. Hemorrhages of the stomach.
7. Arteriosclerosis: a. Coronary (marked), b. Aortic (slight).
8. Arteriosclerosis of kidneys.
9. Hemosiderosis of spleen (moderate).
10. Blood sugar 920 mg. per 100 ml.

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Here we have a boy who developed diabetes at 9 years of age and which, for a long time, was mild. As he reached maturity, he became more and more careless and diabetes became more severe. At 27 years of age he died in diabetic coma and the report of the section shows the extensive findings.

Infection the Cause of Diabetes

Case 2. A boy, 6½ years of age in 1949. In that same year he developed virus pneumonia and diabetes followed immediately after that. I saw him for less than two years, during which time he had to take as much as 16 units of protamine zinc insulin and 23 units of insulin a day and still was not under good control. I lost track of him after June 1950. This instance shows how infection can bring on diabetes quickly.

Case 3. A boy, 8 years old. On June 30, 1951, he developed mumps and I saw him on August 16, 1951, at which time he had a frank case of diabetes mellitus in spite of the fact that his blood sugars on that day showed: 52-308-340 at which time he was taking no insulin. On insulin and diet he has been under a fair control since then and at present, 1957, he is taking 26 units of NPH insulin and 6 units of insulin in the morning.

Mumps frequently is the cause of diabetes in children and one should be on the lookout for it in all cases of mumps.

Hypoglycemia Without Symptoms

Case 4. A girl, 18 years of age. When I first saw her on November 25, 1952, she was taking 20 units of protamine zinc insulin and 40 units of insulin in the morning. At that time she had had diabetes over two years. On that same day and the above dosage of insulins her blood sugars were: 116-47-25 mg. per 100 ml. The interesting thing was that at the time of the low noon and evening blood sugars she had no feeling, nor symptoms, of hypoglycemia feeling perfectly normal. I reduced her insulin and she got along well, not experiencing any insulin reactions.

The patient married in January, 1954 (at age 20) and became pregnant that same year. On November 19, 1954, at which time she was taking 68 units of NPH insulin in the morning, her blood sugars were: 63-31-40 mg. per 100 ml. and again there was no consciousness of hypoglycemia. The insulin dosage was reduced to 60 units of NPH insulin on which she was well controlled. On January 27, 1955, a cesarean section was done, the baby weighing eight pounds. Shortly after that the insulin dosage was gradually reduced to 44 units of NPH insulin with a good control to date.

The interesting thing here is the fact that with such a hypoglycemia the patient was not conscious of it, a fact which I have encountered many a time.

Drop of Blood Sugar Without Insulin

Case 5. This is an interesting case showing a marked drop of blood sugar without insulin. A woman 36 years of age in 1954. She has had diabetes since 1948 and was on 20 units protamine zinc insulin a day on which she was well controlled. She had retinal hemorrhages. I placed her on 20 units NPH insulin a day for four months when all insulin was discontinued. On September 30, 1954, at which time she had been off of insulin for four months, she showed the following figures of the blood sugar: 306-243-72 mg. per 100 ml. and that without any insulin. I then placed her on 10 units NPH insulin on which she is in good control.

The interesting thing here is the fall of blood sugar on September 30, 1954, without any insulin, from 306 to 72 mg. per 100 ml., meals between.

Diabetes in Twins

Case 6. A physician, 65 years old in 1950 when I first saw him. At that time he had had diabetes for just a few months. He was carefully dieting and by this alone had controlled his diabetes well. Two of his sisters were diabetic and a twin brother had developed diabetes at 15 years of age. The physician developed diabetes at 65 years of age.

Many years ago I have shown the incidence of diabetes in twins which can occur either spontaneously or many years apart, a fact to bear in mind in all twins where one is a diabetic. Here we have an instance where one of the twins developed diabetes at 15 and the other at 65 years of age.

Delayed Cases of Diabetes

Case 7. This woman, 46 years of age I saw first in 1938 at which time she had a normal blood sugar two and one-half hours after a heavy carbohydrate meal. This examination was done because in 1921, during her pregnancy, she showed glycosuria and hyperglycemia all during pregnancy. On a restricted diet alone she managed well. However, in 1942, she developed a frank case of diabetes. In 1949 when I first saw her, her blood sugars, three times daily, before meals, were: 109-103-80, the last blood sugar being taken two and one-half hours after a heavy carbohydrate meal. However, in 1950, the blood sugars were: 167-161-107 on diet alone. Since then she remained a mild diabetic. Her mother and her daughter have diabetes. The daughter who was obese, developed diabetes at the age of 16, in 1938.

Case 8. Woman, 49 years of age in 1936. Her history was that seven years previously she showed glycosuria and that she had been on a reduced diet ever since. When I first saw her on Oct. 27, 1938, all her blood sugars were normal and there was no glycosuria. On Nov. 3, 1938, I did a glucose tolerance test which too was normal, in fact on the low side. However, in 1950 when I saw her next, she showed hyperglycemia throughout the the day. Then I did not see her until Oct. 29, 1952, at which time she was taking 40 units NPH insulin a day on which she was well controlled. This dosage, over a period of three years was reduced to 30 units which was quite adequate.

Here we have a woman who in 1929 showed glycosuria and hyperglycemia and who, at that time was on insulin for three months, had straightened out completely and for seven years showed no hyperglycemia. Even when a glucose tolerance test was done this was normal, but 14 years later she developed diabetes again and has it to this day, and is well controlled on 30 units NPH insulin. This confirms the old saying: once a diabetic, always a diabetic even though there may be an interval of a non-diabetic condition between, lasting for several years.

A Mistaken Diagnosis

Case 9. A young girl 17 years of age in 1949. I saw her first when she was sent to hospital because of abdominal tenderness which was interpreted as acute appendicitis. She was sent in for an operation. It was obvious to me that the child was in severe acidosis. Her blood sugar was 450 mg. per 100 ml., CO_2 was 26.7. On heavy dosage of insulin up to 110 units the first day she was soon under control requiring after that only 30 units PZI insulin a day and 20 to 25 units of insulin.

There was no appendicitis and later she was well controlled on 18 units and still later on 12 units of protamine zinc insulin a day which was later reduced to 10 units. All the blood sugars during that time three times a day, before meals, were normal; in other words a perfect control. In fact on July 25, 1950, all insulin was discontinued and all subsequent blood sugars, three times daily, before meals, on that day, without insulin were: 116-227-563. Then evening insulin was resumed and she did quite well on 20-0-20 NPH insulin a day, she went then to college, graduated and married in 1954 and is under good control on 34 units NPH and 16 units insulin taken in the morning.

The point I am stressing is the gastrointestinal upset on Sept. 11, 1950, which completely upset a mild case of diabetes. It also shows the importance of checking the blood sugar three times a day, before meals, for on that day the fasting blood sugar was normal, namely 116 mg. per 100 ml.

Ruling Out Diabetes Does Not Mean That Patient May Not Develop It Later

Case 10. A woman, 52 years old in 1951. At that time she told me that she had had glycosuria for five years. Upon a close checkup on October 29, 1951, diabetes was ruled out although she showed glycosuria. A year later, November 2, 1952, she came in with a fasting blood sugar of 361 mg. per 100 ml. When I straightened her out on insulin and diet, starting with 20 units NPH insulin, she responded quickly, the blood sugar came down to normal in two days and she has been well controlled on 20 and later on 16, then on 10 units a day.

This shows that even though one may rule out diabetes at any particular time, this is apt to come forth at a later date. The glycosuria alone, when I first saw her, in the presence of blood sugars 74-87-41 certainly could not have been considered as diabetes, even now in retrospect.

Acute Hepatitis and Steroids

Steroids are said to shorten the course in some cases of infectious hepatitis and are more likely to be helpful in severe than in mild cases. Some patients have been made worse. It appears that the cholangiolitic type of viral hepatitis is benefited more than other types.

In general, however, it would appear that steroids should probably not be used in this disease until more information is available regarding results of treatment except perhaps in severe progressive hepatitis.—Kenneth B. Castleton, M. D., Salt Lake City, Utah: *Rocky Mountain M. J.*, 55: 41, August, 1958.

Follow-Up Care Outlined To Maintain Normal Weight

Obesity, like diabetes, is not cured, but controlled. Thus, after attaining normal weight, the patient must be taught how to maintain it. It is unusal for him to lose his excessive desire or compulsion to eat just because he has been on a weight reduction program. The person who tends to gain weight never loses the tendency. Only rarely does a patient who has successfully reduced say: "I no longer have the desire to eat that I used to." With this in mind, the following principles have been established in follow-up care:

(1) The food plan, high protein, low fat, low carbohydrate, and calorically adjusted to individual needs, must be life-long.

(2) The patient must maintain his enthusiasm for normal weight by continuing to be weight-conscious. He should weigh once weekly.

(3) He must see the physician at intervals of every three months for at least a year after normal weight has been maintained.

(4) An anorexigenic agent may be prescribed intermittently to help control appetite. It should be taken during periods of stress or when the patient notices weight beginning to creep up again. Saturdays, Sundays and holidays particularly seem to encourage over-eating.

(5) Physical activity should be maintained just as during the weight reduction program.—Robert H. Barnes, M. D., Seattle, Wash.: *Northwest Med.*, 57:1011, August, 1958.

Cholecystectomy Before and After 48-Hour Optimal Period

At the present time it seems fair to say that the majority of authors agree that cholecystectomy is indicated within the first 48 hours following the onset of an acute attack if the patient's condition warrants surgery, and if proper hospital facilities and well-trained professional personnel are available. It is with reference to the patient whose disease has progressed *beyond* this point that the debate rages. The articles through which the battle has been waged contain reports of mortality and morbidity, and comparisons of results can be obtained by referring to them. A review of typical mortality figures in cases operated upon for acute cholecystic disease at "the optimum time" reveals a range of 2.4 to 3.5 per cent in series containing from 84 to 527 cases. In one recent series of 103 seriously-ill patients treated surgically, the mortality rate was 9.1 per cent.—J. K. MacGregor, M. D., Mason City, Ia.: *J. Iowa M. Soc.*, 48:502, September, 1958.

A Study of *Staphylococcus Aureus* in Akron Hospitals

LEROY G. DALHEIM, M.D., JOHN D. MORLEY, M.D.,
and EARL E. LONG, M.S.

THE isolation of the so-called "epidemic strain" of staphylococcus aureus coagulase positive phage type 47C/52/80/81 from adult medical patients in January, 1958, in an Akron hospital prompted an epidemiologic investigation of the incidence of this organism by the Akron Health Department. It had been thought that this epidemic strain of staphylococcus was chiefly a problem for the nursery and the newborn infant. The isolation of this bacterial agent in adults was the first confirmed instance of this problem known to the Ohio Department of Health.

Recent reports from all over the nation have stressed the increasing awareness of the problem of staphylococcus in current medical therapy. With the isolation of the organism in two patients in the Akron area in whom infection was not the primary cause of hospital admission, further investigation from a public health standpoint was thought advisable. The case histories of the two patients were prepared as a preliminary step. These are presented. (This hospital will hereafter be known as Hospital A.)

Case 1. The patient, a male, age 74 years, was admitted to a medical floor on December 14, 1957, with a diagnosis of myocardial infarction. He was afebrile until January 5, 1958, when he spiked a temperature of 102°. A chest x-ray on January 6 revealed an infiltration of the right upper lobe. A sputum culture on January 9 revealed S. aureus coagulase positive phage type 47C/52/80/81. He received penicillin and was discharged on January 13, 1958, improved. He was readmitted January 30, 1958, in coma with thrombophlebitis of the left leg. X-ray of the chest showed pneumonia of all lobes of the right lung. He was treated with Chloromycetin® and penicillin but expired on January 31, 1958.

Case 2. A male patient, age 67 years, was admitted to a surgical floor on January 17, 1958, because of rectal bleeding. He was afebrile on admission. Sigmoidoscopy was performed and on January 20, 1958, a barium enema revealed a filling defect of the cecum. Chest x-ray on this date revealed congestion of both lower lobes and a chronic pneumonic infiltration. On January 22 he spiked a temperature of 103.6° at a time when the chest was clear of rales. A blood culture drawn on January 22 grew S. aureus coagulase positive phage type 47C/52/80/81. He expired suddenly on January 25. Autopsy revealed bilateral pneumonia and acute cerebral infarction.

Since the problem had been known to exist in nurseries, a plan was devised to visit the nurseries of Hospital A and culture all infants over 24 hours of age. This was felt to be a captive population and an efficient way to measure the incidence for the hospital. At the same time, the laboratory of this hospital was requested to send all coagulase positive staphylococci from all patients to the State Department of Health Laboratory for phage typing for their own information. On February 24, 1958, one of us (L.G.D.) visited the nurseries and cultured all the infants as planned. A revisit on March 18, 1958, was also done because of the findings on the first culture group. The data are summarized in table 1.

The Authors

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- **Mr. Long, Akron, is Director of Laboratories, Akron Health Department.**

TABLE 1.—*Data of Nursery Cultures Hospital A.*

	Negative for Staphylococci	Coag. Pos. Staph. but not 80/81	Epidemic Strain Isolated	Total
Newborn Infants February 24, 1958	19	15*	10**	44
Newborn Infants March 18, 1958	18	12*** 2* 1****	1**	34
Nursery Personnel March 18, 1958	18	2* 1*** 2****	0	23

* untypable
** 47C/52/80/81 or 42 B/47C/52/80/81
*** 44 A
**** Miscellaneous types

The finding of 10 infants with the epidemic strain in the February 24 study was deemed so high that epidemiologic investigation was carried out by a nurse investigator from the U.S. Public Health Service, then working with the Ohio Department of Health, and a Public Health Nurse of the Akron Health Department. In the interval between the first isolation of the epidemic strain in adult patients in Hospital A, other family groups in whom this organism was isolated in newborn infants became known to the Akron Health Department. Accordingly, home visits were made to a total of 12 family groups by the two. The data

TABLE 2.—*Data of First Epidemiologic Study.*

Family	Pathology of baby	Pathology of mother	REPEAT CULTURES DONE		
			March 26, 1958	April 1958	May 1958
1. Ku	Breast abscess	Breast abscess	Baby N-P Neg. Mother N-P Neg.		
2. Roc	N-P carrier 80/81	Breast abscess	Baby N-P Pos.* Mother N-P Neg.	Baby N-P Pos.* Lesion Pos.* Mother N-P Neg.	Baby N-P Pos.* Mother N-P Neg.
3. Ri	Furuncle	Furunculosis	N-P Baby Lesion } Pos.* Mother N-P Neg.	Baby Lesion Pos.* Mother N-P Pos.*	Baby N-P Pos.* Mother N-P Pos.*
4. Fi	N-P carrier 80/81	Nasal Furuncle	Baby N-P Pos.* Mother N-P Pos.* Lesion Neg.		
5. Pe	Furunculosis	Breast abscess	N-P Pos.* Baby Rash Pos.* Mother Breast Drainage +N-P Pos.*	Baby Lesion Pos.* Mother N-P Pos.* Lesion Pos.*	Baby N-P Pos.* Mother N-P Pos.**
6. McG	Axillary furuncle	None	Baby N-P Pos. 44A Mother N-P Neg.		
7. Da	N-P carrier 80/81	Breast abscess	Baby N-P Pos. 52/80 Mother N-P Pos.*		Baby N-P Pos.** Mother N-P Pos. 44A
8. Ru	N-P carrier 80/81	None	Baby N-P Pos.* Mother N-P Neg.	Baby N-P Pos.*	Baby N-P Pos.* Mother N-P Neg.
9. Bo	Impetigo	None	Baby N-P Neg. Mother N-P Pos.*	Mother N-P Pos.*	
10. Roh	N-P carrier 80/81	None	Baby N-P Pos.* Mother N-P Neg.	Baby N-P Pos.*	Baby N-P Pos.** Mother N-P Pos.**
11. Co	N-P carrier 80/81	None	Baby N-P Pos. U Mother N-P Neg.		Baby N-P Pos. U Mother N-P Neg.
12. Ty	N-P carrier 80/81	None	Baby N-P Pos.* Mother N-P Pos.*	Baby N-P Pos.* Mother N-P Pos.*	Baby N-P Pos. U

(The epidemic strain of staphylococcus is frequently abbreviated by the numerals 80/81)
*—42B/47C/52/80/81
**—47C/52/80/81
U—Untypable strain
Neg.—Negative for staphylococcus aureus
N-P —Nasopharynx
Pos. —Positive for staphylococcus aureus

from these visits are summarized in table 2.

The Pe and Roc families (Case 5 and Case 2) deserve special note. Mr. Pe developed a perineal abscess in June, 1958, which required surgical drainage. A S. aureus phage type 47C/52/80/81 was isolated from this infection four months after the first demonstration of this bacterial agent in the family group. Baby Roc continues to have skin lesions from which the epidemic strain of staphylococcus was isolated on July 9, 1958.

The data compiled after the first epidemiologic study revealed a potentially more serious public health problem than had been anticipated. For this reason the medical staff members of the Health Department presented suggestions to the administrations of the three Akron hospitals in which maternity units are located. At the request of, and with the cooperation of the administration of these hospitals, a study was undertaken to ascertain the degree of "saturation" of the three hospital nurseries with the epidemic strain of staphylococcus.

The purpose of this study was threefold. First, it was deemed important to ascertain exactly how great a reservoir of the epidemic strain of staphylococcus was present in our hospital population. Secondly, it was hoped that by determining how great a potential threat existed, we could institute measures to minimize the problem. And third, we hoped to be able to present the data to the medical community to demonstrate how important this "common contaminant" has become.

Method of Study

It was decided that all newborn infants in the three Akron hospitals would have a nasopharyngeal culture done at the time of discharge from the nursery. Culture materials were to be supplied by the laboratory of the Akron Health Department with the cultures to be taken by the nursery personnel of the individual hospitals. The cultures were to be picked up daily by the Akron Health Department Laboratory and the original bacteriological isolations were to be done by this laboratory.

Cultures were taken using braided picture wire to which a small amount of cotton was applied to one end using collodion. After culturing, swabs were placed in salt broth media (brain heart infusion broth to which 7 grams of salt per 100 ml. of media was added). Incubation at 37° C for 24 hours was done. The salt broth cultures were streaked onto mannitol salt agar (Bacto Phenol Red Agar, Difco Laboratories, to which 7 grams of salt per 100 ml. of media was added). Incubation was done for 24 hours at 37° C. Mannitol positive colonies were picked and inoculated onto plates of heart infusion agar (no salt added). These were incubated for 18 to 24 hours and used for coagulase testing and sensitivity tests. Those colonies which were coagulase positive were sent to the Ohio Department of Health Laboratory on heart infusion agar slants to which 7 grams of salt per 100 ml. of media was added for phage typing. All phage typing in this study was done by the Communicable Disease Laboratory of the Ohio Department of Health.

Home visits were to be made on all families in which the epidemic strain of S. aureus was isolated by the Public Health Nurses of the Akron Health Department (or the Summit County Health Department for families residing outside Akron limits) at monthly intervals following discharge from the nursery. At the time of the home visit, repeat cultures were to be taken of the nasopharynx of both mother and baby, as well as any other member of the family unit in whom staphylococcal disease were suspected at that time. In addition data were to be compiled concerning any infectious lesions in the family group.

In order to assure that the practising physicians would be aware of the presence of this organism in their patient-families, a letter was to be sent by the health department which served to notify the physician of the presence of the bacterial agent and to give him the antibiotic sensitivity pattern. This was carried out in all cultures done.

The proposed investigation was heartily accepted by the three hospitals and the study began in early April, 1958. During the period of study which ended on May 16, 1958, a total of 1,282 cultures were done. The data are given in table 3.

TABLE 3.

Hospitals	No. of Newborn Cultures	No. Positive for Epidemic Staphylococcus
A	323	2
B	773	30
C	186	14
Totals	1282	46

Results

Of the 1,282 cultures taken, 46 were found to be positive for the epidemic strain. Thirty-four home visits to these family units were made. The data from these visits are presented in table 4.

It is of interest to note that only two positive cultures were obtained from Hospital A, an incidence of 0.6 per cent. In Hospital B, we found 30 positive cultures out of a total of 773, an incidence of 3.88 per cent. There were 14 positive cultures out of 186 in Hospital C, an incidence of 7.52 per cent.

It is also of interest to note that there was much less serious after effects in the family groups studied than in the first investigation in March (table 2). There were five cases of breast abscesses in these 12 families. In the last study group there was one instance of a breast abscess in an infant; the remaining pathological processes were restricted to less severe skin infections.

In addition to the visits made by means of nursery-screened families, the public health nurses of the Akron Health Department investigated 15 family units in whom staphylococcal disease was suspected. These families were encountered in everyday nursing contacts. Sixty-two cultures were done in this group. Thirteen of these were of the epidemic strain of staphylococcus and follow-up visits were made.

That the same bacterial organism can cause varying types of pathology in different persons is well known. This is probably the only explanation for the great incidence of serious pathological processes in our first investigation and the relatively minor morbidity in the second.

Since the conclusion of the study period, we have not been aware of any further difficulty among the newborn infants or their families.

Summary

A study of the incidence of the epidemic strain of S. aureus phage type 42B/47C/52/80/81 and 47C/52/80/81 in the Akron area is presented. Follow-up visits are presented. The study carried out by the health department has resulted in some changes in nursery policy which we feel has been of great help in controlling the spread of this organism.

Better working relationships were achieved between the Akron Health Department and its laboratory and the three hospitals involved in the study. The hospital staffs and administrations were made more aware of the threat of S. aureus for all patients. An infections committee was established in the hospitals as a result of the findings of this study. This will help maintain the high level of asepsis and surveillance which is so necessary in prevention of the spread of infection.

This study served to acquaint the hospitals with the services of the Communicable Disease Research Laboratory which they are continuing to use in staphylococcal disease control.

Acknowledgments: The authors gratefully acknowledge the help given them by the nursing staffs of the Akron Health Department and the Summit County Health Department in making all home visits in this study. Members of the laboratory staff of the Akron Health Department were instrumental in the successful completion of the report by their work in providing culture media and in doing all bacteriological isolations prior to submission for phage typing. Also our thanks to Dr. Frederick H. Wentworth and Dr. Winslow Bashe of the Ohio Department of Health; Mrs. Berttina Wentworth of the Communicable Disease Research Laboratory, Ohio Department of Health, with her staff, did the phage typing.

TABLE 4.—*Summary of Data Obtained from Home Visits.*

Family	Date Original Nursery Culture	Date Repeat Culture	Pathology	Miscellaneous
Hospital *A* Hi	4- 2-58	B 5-5-58 Pos.*	None	7-1-58 B-Pos.* 7-1-58 M-Neg.
Ko	5- 4-58	B 6-23-58 Pos.* M 6-23-58 Neg.	None	
Hospital *B* Ca	4-22-58	B 5-23-58 Pos.*	Eye infection - Rash of chest and abdomen	6-17-58 No further difficulty
Gu	5-10-58	B 5-14-58 Pos.* M 5-14-58 Neg.	Blebs on abdomen	
He	5-10-58	B NP 6-5-28 Pos.* Lesion 6-5-58 Pos.*	Eye infection	7-1-58 B-Pos.* 7-1-58 M-Neg.
Wh	4-27-58	B 6-5-58 Pos.* M 6-5-58 Pos.*	None	7-3-58 B-Pos.* 7-3-58 M-Pos.*
Bl	5-16-58	B 7-7-58 Pos.* M 7-7-58 Neg.		
Co	4-17-58	B 5-14-58 Pos. 44A M 5-14-58 Neg.	Rash	
Va	4-17-58	B 5-19-58 Pos.* M 5-19-58 Pos. U		6-58-B-Pos. U
Ma	4- 7-58	B 5-6-58 Pos.* M 5-6-58 Pos.*	Impetigo	6-6-58 B-Neg.
Fa	4-22-58	B 5-2-58 Pos.* M lesion 5-2-58 Pos.*	Infected episiotomy	7-1-58 B-Neg. 7-1-58 M lesion Neg.
Be	4-28-58	B 5-29-58 Pos.* M 5-29-58 Neg.		7-1-58 B-Neg. 7-1-58 M-Neg.
Th	4-18-58	B 5-16-58 Pos. U		
Pe	5-15-58	B 6-1-58 Pos. U M 6-1-58 Neg.	Rash on head	
Wi	5-16-58	B 6-25-58 Pos. U M 6-25-58 Neg.		
Ma[t]	4-26-58	B 5-21-58 Neg. M 5-21-58 Neg.		
Wa	4-19-58	B 5-21-58 Neg. M 5-21-58 Neg.		
Li	4-25-58	B 6-4-58 Neg. M 6-4-58 Neg.	Pustular dermatitis	
Ak[t]	4-17-58	B 5-19-58 Neg. M 5-19-58 Neg.	Baby has skin lesion Mother had jaw abscess	
Tu[t]	4-20-58	B 6-13-58 Pos.* M 6-13-58 Neg.		
Te[t]	5-13-58	B 6-25-58 Neg. M 6-25-58 Neg.	Baby had erythematous rash; Mother had pustular lesion of face	
Hospital *C* McL	5-13-58	B 6-10-58 Pos.* M 6-10-58 Pos.*		7-17-58 no evidence of infection
Sh	5-16-58	B-6-25-58 Pos.* M 6-25-58 Neg. F 6-25-58 Lesion Pos.*	B infection of perirectal area and abscess of neck. M infection of lip. F abscess	8-4-58 no lesions present
Wi	4-30-58	B 5-29-58 Pos.* M 5-29-58 Neg.	Boils on baby	7-58 baby had abscess of neck, NP & lesion Pos.* Mother neg.
Sm	4-25-58	B 5-28-58 Pos.* M 5-28-58 Pos.*		Moved—no return visit
Ne	4-20-58	B 5-16-58 Refused culture M Pos.*		No lesions noted
Li	4-16-58	B 5-15-58 Pos.*	Lesions on baby's face	6-26-58 Return visit cultures negatives
Cr	4-22-58	B 6-6-58 Pos.* B 6-6-58 Pos. 44B	Blebs on arm	
Bu[t]	5-11-58	B 6-11-58 Pos.* M 6-11-58 Neg.		
Lo	4-30-58	B 6-5-58 Pos. 39/51 M 6-5-58 Neg.	Pustular dermatitis	No return visits made
Pa[t]	4-21-58	B 5-29-58 Neg. M 5-29-58 Neg.	No lesions	
Dy[t]	4-26-58	B 5-29-58 Neg. M 5-29-58 Neg.	B skin lesions at 10 days of age	7-58 B has infected rash. M has boils.
Mi	3- 8-58	B 5-16-58 Pos. U M 5-16-58 Pos. U	Rt. breast abscess in baby	
Me	5-14-58	B 6-19-58 Pos.* M Refused	Baby had mild pustular dermatitis. Mother had bleb on thigh.	

KEY: (All cultures are nasopharyngeal unless otherwise noted.)

Pos. — Postive for staphylococcus aureus.

Neg. — Negative for staphylococcus aureus.

* — Epidemic strain (42B/47C/52/80/81 or 47C/52/80/81) Other types are given in tables.

U — An untypable strain of staphylococcus aureus.

B — Baby; M - Mother; F - Father.

t — Visits made by Public Health Nurses of the Summit County Health Department.

Exposure Keratopathy

A Case Report on Preventable Blindness

WILLIAM H. HAVENER, M. D.

A BLIND EYE is a serious loss to both patient and community. Awareness of the preventable nature of a significant portion of this blindness should help in reducing the incidence of such tragedies. The representative cases to be presented here are selected to emphasize relatively common causes of blindness which can in many instances be averted by proper, timely care.

Case Report

A 29 year old nurse underwent surgery for a parotid malignancy. Unavoidable damage to the 7th nerve was incurred during surgery. This rather prolonged operation was scheduled late in the day, and as a result the semiconscious patient did not return to her hospital ward until evening. She did well and had an uneventful hospital course with one significant exception. Unfortunately the nursing and medical staff failed to realize that the combination of 7th nerve paralysis and postanesthetic lethargy resulted in continuous exposure of her left cornea during the entire night. Within this 12 hour period there resulted sufficient dehydration of the corneal surface and superficial bacterial infection to leave permanent scarring of her central cornea. Simply the instillation of lubricant ointment and closure of her lids would have prevented this tragedy. To this day, her vision O. S. is limited to recognition of the big "E" on the Snellen chart.

Discussion

Exposure keratopathy is one of the most easily preventable forms of eye damage. This ease of prevention is indeed fortunate, since exposure keratopathy is a most common threat to the eye. Any unconscious patient is a potential candidate for corneal damage if his eyes are not closed. This is true whether unconsciousness is from an auto accident, a fall, serious medical disease such as an acute cardiac episode or a cerebrovascular accident, or is iatrogenically induced by anesthesia in the course of a tonsillectomy. A surprisingly short duraation of exposure is necessary to cause serious corneal damage. Dramatic evidence of the shortness of this time is repeatedly seen in routine obtaining of corneas for transplantation. As short a time as 30 minutes with open lids renders the cornea unsuitable for transplantation.

Mechanical failure of the lids to close will also result in exposure keratopathy. Exophthalmos is a common cause, and may result from thyrotrophic disorder, orbital tumor, or orbital cellulitis. Ectropion (cicatricial, paralytic, senile, or spastic) may be severe enough to cause localized corneal exposure. Such damaged areas of corneal surface may act as portals of entry for bacterial infection. Bell's palsy is one of the more common causes of chronic corneal exposure. Trauma may leave gaps in lid closure which must be corrected promptly. During all ocular and lid surgery, the operation needs constantly to keep the cornea moist.

The Author

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Inadequate tear secretion will also cause corneal drying and scarring. The severest cases are seen when the conjunctival goblet cells are destroyed by diseases such as pemphigus, trachoma, Stevens-Johnson syndrome, or extensive chemical burns. Keratoconjunctivitis sicca (dry eyes) is a lesser degree of lacrimal deficiency occurring commonly in arthritic, menopausal females.

Therapy

Therapy is simply protection of the cornea by means of ointment, lubricant drops, bandages, or sutures. Recognition of the need for such protection is the duty of each doctor and nurse. Instillation of 5 per cent boric acid ointment is routine in every general anesthetic at the University Hospital. Such simple care will almost invariably prevent "ether burns of the eye" which may occur without the use of ether at all and usually represent exposure damage due to negligence. Similar treatment is indicated for all semiconscious patients with inadequately closed eyes. Boric acid ointment is chosen because it is cheap and effective and there is no need in these prophylactic circumstances for the more expensive steroids or antibiotics. Eye pads are also effective, but must NEVER be applied dry, as the lids will open beneath the pad and its rough surface will cause severe corneal abrasions. Such a pad must always be well greased and applied to the *closed* lids.

For chronic low grade exposure such as seen in Bell's palsy or thyroid exophthalmos, 1 per cent methylcellulose is a most useful lubricant drop. This substance is quite viscous and protective, yet is water soluble and nongreasy. It does not produce the misty visual disturbance which is so annoying with ointments.

Prevention of Corneal Exposure

Acute severe corneal exposure such as may be threatened in lid trauma or orbital edema is often best prevented by closing the lids with a mattress suture through their margins. The skin bite should extend at least 3 mm. from the lid margins. A 4-0 suture size is optimal. Depth of the suture should include part of the tarsal plate, with the needle traversing the gray line in the middle of the lid margin. Under no circumstances should the suture emerge on the inner surface of the lid, as this will result in corneal abrasion.

The double-armed suture should pass through and be tied on top of a piece of rubber band in order to prevent cutting through the skin. The lid edges should only be loosely approximated, for a tighter suture will cut through the lid margin, leaving an unsightly notch. Such a lid suture may be left in place for up to a week. Should a longer period of lid closure be necessary, a tarsorrhaphy is necessary. This consists of denuding opposing lid edges of epithelium and suturing them together to obtain permanent adherence.

Eternal vigilance and prophylactic ointment will prevent eye damage from exposure keratopathy!

Mechanism of Action of Oral Diabetic Therapy

1. The active sulfonylurea compounds, in general, exhibit a blood sugar-lowering effect which depends, within limits, on the dosage.
2. The sulfonamide group, apparently, is the most active, although many methyl-ethyl-hexyl compounds could be employed with much less success.
3. Little effect is seen in cases of diabetes following pancreatectomy, or in patients with genuine insulin insensitivity, or in the hyperglycemia after adrenalin and glucagon.
4. These drugs probably do not act by inhibiting glucagon secretion and damaging the alpha cells. There is little evidence that they act by depressing insulin antagonists. It is pretty clear that the sulfonylureas, including Orinase, can depress the action of the hepatic enzyme systems which operate upon the transformation of such substances as fructose to glucose. They probably inhibit the action of the proteolytic enzymes known as insulinase, although this effect has not been confirmed.—Howard F. Root, M. D., Boston: *North Carolina M. J.,* 19:293, August, 1958.

Early History of Therapeutic Use of Tobacco

Many of the early synonyms for *Nicotiana* bear witness to the supposed therapeutic virtues of the plant: *Herba Panacea; Herbe propre á tous maux; Heilkraut.* The pharmacopoeias, official or unofficial, invariably included *Tabacum* (indeed, as late as the United States Pharmacopoeia of 1890), although by the 18th Century it had already been noted that tobacco was even then used more for amusement than for its medicinal virtues (Alston, 1770); and by the early 19th Century, the potential dangers of tobacco as a drug were well known. . . .

In former years, tobacco was recommended as a remedy for relief of asthma on account of its antispasmodic effects (W. S. Thomas, 1928). "In disordered respiration," wrote Sigmond (1838f), "this herb obtained the well-merited confidence of the older physicians, in cases [of spasmodic asthma] where no organic alteration has occurred. It has, however, nearly fallen into neglect, from which state it will most probably revive, for it has lately been tried to a very great extent, and with no small success, under a false name [a spirituous tincture of the tobacco having been supplied to physicians under the name of *Lobelia inflata,* which latter drug was then in great demand]. My own experience had led me to its frequent employment; nor did I discover for some time the artifice which had been practiced. It, however, induced me to place great reliance on the aetherial tincture of tobacco, to mitigate the paroxysms of spasmodic asthma. It must, however, be remembered that where the lungs are diseased, it is capable of exacerbating the complaint, and that it always demands the careful discrimination and judicious watchfulness of the medical man."' Sée (1869) also held that the actions of tobacco were antagonistic to asthma; hence, he recommended the moderate use of tobacco by asthmatics but at the same time cautioned that immoderate use provoked attacks. P. Smith (1890) recorded the case of a woman who had used tobacco for years for the relief of asthma, who eventually developed tobacco amblyopia.

The mixture of tobacco and leaves of the thorn apple *(Datura stramonium)* has, from olden times, been used as a remedy for asthma in the form of so-called "asthma cigarettes." Lickint (1925c) believed that the nicotine of the tobacco weakened rather than reinforced the bronchial antispasmodic action of *Datura stramonium,* and therefore, advised inhaling the smoke of burning stramonium leaves alone.—H. Silvette, Ph. D., et al.: *Virginia M. Monthly,* 85:472, September, 1958.

MATERNAL HEALTH IN OHIO

THE Committee on Maternal Health proudly presents this, its initial annual report. It consists of a Maternal Mortality Study covering the 88 counties of Ohio for the year 1955. The statistics have been compiled and are published in compliance with a House of Delegates directive adopted April 23, 1953, creating this Committee; and follow-up action taken by The Council on January 16, 1954.[1]

As prescribed, the activities of the Committee are statistical and educational. They consist of:

1. The operation of a voluntary, scientific study of all maternal deaths in Ohio, assisted by various agencies, organizations and individual physicians of the state.*

2. The maintenance of an education and training program for Ohio physicians pertaining to the practice of obstetrics. Material for the project is selected from data and experiences gained from the Ohio Maternal Mortality Study, and is applied in the following phases:

   a. Publication of the "Maternal Health in Ohio" column, *The Ohio State Medical Journal,* on a monthly basis, beginning with Volume 52, September, 1956.*

   b. Support of a program operated by the Ohio Society of Anesthesiologists to train physicians in the administration of proper anesthesia for use upon obstetrical patients.

   c. Provision of minimum, uniform standards of obstetric care through "Guiding Principles for Obstetric Care,"[2] published by the Committee, and approved by The Council.

   d. Preparation of data and information on various phases of obstetric management, for use by various local medical groups throughout the state. These include outlines as well as visual aids.

3. The Committee acts as an advisory body to The Council in matters pertaining to Maternal Health in Ohio.

TOPIC THIS MONTH:

Maternal Mortality Report For Ohio—1955

Terminology and nomenclature used herein have been adopted after prolonged study. For the purpose of uniformity, certain nomenclature follows that employed in The Manual of the International List of Causes of Death.[3] All terms and nomenclature have been published previously,[1] and will not be reviewed at this time.

The statistics for 1955 are presented logically and concisely to enable the reader to compare this report with similar documents in the future. Additional reference will be made to this data in subsequent issues, at which time they may be elaborated upon.

Ohio Maternal Mortality Study Statistics for 1955

Total live births in Ohio, 1955	**222,689**
Total cases studied	119
Cases not studied due to lack of information	2
Maternal Deaths (classified)	**96**
White	77
Non-white	19
Age:	
Teens	8
20's	37
30's	40
40's	11
Parity:	
Primigravidae	29
Multiparae	65
Unknown	2
Place of death:	
Hospital	89
Other	6
Not known	1
Method of Delivery:	
Operative	52
Nonoperative (spontaneous)	26
Not delivered (incl. postmortem deliveries)	18
Route of delivery:	
Vaginal	57
Cesarean: (ante mortem)	21
(postmortem)	7
Not delivered	11

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*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by official representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

Case classification: (when death occurred)		
Group I (fr. concept. to 20th wk.)		6
Group II (fr. 20th up to 28th wk.)		0
Group III (fr. 28th wk. through term)		10
Group IV (postabortal, postpartum)		80
Autopsies		58
(Coroners cases, 14)		
Classification of preventability:		
Nonpreventable		46
Preventable		50
Patient Responsibility (P_1)	11	
Personnel Responsibility (P_2)	33	
Both (P_1 and P_2)	6	
Prenatal Care (Apparent from data sheets)		
Adequate		55
Inadequate		15
None		12
Excluded (ectopic preg. and abortion)		5
Not reported		9

Classification of Primary Causes of Death:

Hemorrhage		15
Abortion	1	
Abruptio	1	
Afibrinogenemia	1	
Ectopic pregnancy	4	
Laceration	3	
Placenta Praevia	3	
Postpartum (atony, etc.)	1	
Ruptered uterus	1	
Infection		12
Abortion, septic (including alleged "criminal abortion")	9	
Puerperal (true)	2	
Other: Peritonitis (non-puerperal)		
Tuberculosis		
Up. Resp. Inf.	1	
Toxemia		9
Chronic Hypertension (including hypertension with cerebrovascular accident)	2	
Eclampsia	5	
Pre-eclampsia	2	
Other		60
Amniotic fluid embolus	6	
Anesthesia (General)	8	
Anesthesia (Regional)	6	
Blood dyscrasias		
Cardiac disease	11	
Cerebrovascular accident (no hypertension)	6	
Diabetes	3	
Liver diseases	3	
Lower nephron nephrosis	2	
Malignancy		
Pulmonary embolus	8	
Renal disease	1	
Other (suicide, psychosis, respiratory failure, etc.)	6	

In Ohio, there were 222,689 live births reported for the year 1955. From this study, classifying 96 maternal deaths for the year, the maternal mortality rate was 0.431 per 1,000 live births, or 4.31 per 10,000 live births.

Discussion

The Committee reviewed every case thoroughly and studied the facts and data. Final classification of each case was made solely upon available information. In many cases this was abundant, but in some it was extremely meager. The minimum standards prescribed in "Guiding Principles for Obstetric Care" were used as a guide to grade preventability in each case. An effort was made to render a final opinion which was justifiably correct. Of the 121 cases received, two could not be completed due to a lack of available information at county level. The great majority of deaths, 65, occurred among multiparae, and there were only 58 autopsies in the 96 maternal deaths. Fifty-two per cent of the maternal deaths were voted preventable on the basis of the data available.

Under Primary Causes of Death, hemorrhage led with 15. It is interesting to note that 60 of the 96 maternal deaths were due to conditions *other* than hemorrhage, infection or toxemia.

Among these "Other Causes," anesthesia was responsible for more deaths than was any other individual category. It was also higher than infection or toxemia, which caused 12 and nine deaths, respectively. This would indicate a need for further education in the field of obstetric anesthesia.

Cardiac disease with 11, and pulmonary embolus with eight, were the next most frequent causes of death under "Other Causes."

Future Plans

The Committee recommends that this project with its many phases be continued with renewed vigor, to reduce further maternal mortality (and morbidity) in Ohio. Plans are being made to tabulate and publish similar statistics each year so as to portray accurately the problems and difficulties encountered in obstetric practice in Ohio. This will be accomplished by a use of uniform nomenclature and classification of maternal deaths. To achieve this goal, however, the Committee encourages an improvement in case records written by personnel who attend obstetric cases throughout the state.

The Committee gratefully acknowledges the assistance afforded by attending physicians, representatives of the various County Medical Societies, the Ohio Department of Health, and other organizations. Without their untiring cooperation this study could not have been compiled.

Respectfully submitted,

ANTHONY RUPPERSBERG, JR., M. D., *Chairman*
Committee on Maternal Health.

Approved by The Council of the Ohio State Medical Association, September 14, 1958.

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3. Manual of the International List of Causes of Death, Chapter XI, 640-689 (pp. 178-188) 1949.

A Clinicopathological Conference

Edited Under the Auspices of the Ohio Society of Pathologists

WILLIAM SINCLAIR, M. D., *President*

Presentation of Case

THIS 49 year old white female entered University Hospital, Columbus, Ohio, with the chief complaint of acute abdominal pain of three days' duration. She had a history of tonsillectomy at the age of 15, appendectomy and tubal ligation when she was 19, and a cholecystectomy at the age of 24, following which she had avoided greasy foods as these tended to cause nausea and vomiting. For many years she had suffered from biweekly episodes of left frontal headache with occasional photophobia, followed by severe nausea, vomiting and upper abdominal pain.

At the age of 34 she had another laparotomy, for unknown reasons, and was told that she had many adhesions. Some years ago an abscess around the rectum had to be incised, resulting in an anal stricture which caused constipation and required frequent enemas. In the past year her attacks of headache, nausea and vomiting had become more frequent and lasted from one to several days. Three weeks ago she was hospitalized in her local hospital for similar complaints and was told that she had a scarred duodenum on x-ray examination. She had a barium enema and had been passing blood and mucus from the rectum several times daily since. She left her local hospital after two weeks feeling vaguely unwell.

Four days prior to admission to University Hospital she developed a severe noncramping lower abdominal pain together with a severe lumbar and sacral pain. This latter pain caused much distress, sleeplessness, nausea and vomiting. She had eaten almost nothing in the past three days since the intake of food was followed by vomiting and also aggravated the abdominal pain. She apparently had always been of a nervous disposition, and had amenorrhea since age of 36. The patient was married, had no children. Her family history was noncontributory.

Physical Examination

The patient was well developed, well nourished and appeared in acute distress. She was pale, dehydrated and heavily narcotized. Her temperature was 98° F., pulse 104, blood pressure 120 over 85 and respirations 40. The skin was cold and dry, her lips slightly cyanotic. The chest was clear to percussion and auscultation. The heart showed no murmurs and was not significantly enlarged. The abdomen showed moderate diffuse distention, with hypoactive bowel sounds and generalized tenderness to deep palpation, which was more marked over both upper quadrants. The rectal sphincter was stenosed.

Presented by

- **Henry E. Wilson, M. D., Columbus, and**
- **Emmerich von Haam, M. D., Columbus.**

Edited by Dr. von Haam.

Laboratory Data

Her hemoglobin was 12.7 Gm.; hematocrit 39 per cent; white blood cells 16,700 with 84 per cent polymorphonuclear leukocytes. The urinalysis showed 3 plus sugar and was positive for acetone. Serum amylase was 85 units; sodium 144 mEq., potassium 4.0 mEq., chlorides 107 mEq.; CO_2 combining power was 39 vol.; blood urea nitrogen 19 mg.; prothrombin 29 per cent; total plasma protein 5.3 Gm. (albumin/globulin ratio 3.6/1.7). Thymol and van den Bergh were negative. The blood sugar was 110 milligrams.

Roentgenographic Data

There was no evidence of active cardiac or pulmonary disease. The ascending colon was moderately distended and showed several fluid levels. Some small bowel loops appeared filled with fluid and gas, and two days later fluid could be recognized in the peritoneal cavity. Subsequent upright and supine films of the abdomen showed a moderate amount of air without evidence of fluid levels in the stomach and small bowel.

Hospital Course

Her abdominal pain remained essentially unchanged. Constant gastric suction was carried out and she received intravenous fluids containing vitamin B and potassium supplements. Her abdomen became silent and she stopped passing flatus.

Surgery was considered undesirable in view of the patient's general condition and a pulse rate of 120. An abdominal paracentesis yielded 20 cc. of serosanguineous fluid which had an amylase content of 124 units. Malignant cells were not observed in this material. Frequent blood counts revealed a drop in hemoglobin to 7.7 Gm., a hematocrit of 24 on the second hospital day, and a rise in white blood cells to 24,800 with 74 per cent polymorphonuclear leukocytes.

She received several units of whole blood and the hemoglobin rose to 10.8 Gm., while her white blood count dropped to 12,000. On her third hospital day her abdomen was becoming distended and tympanitic with absent bowel sounds and more marked guarding, especially over the left upper quadrant. Large amounts of brownish fluid were being aspirated via Levin tube. Blood transfusion was continued, together with intravenous fluids. She complained much of thirst.

On the fifth day she appeared more alert with some decrease in abdominal distention. However, she developed asthmatic type of dyspnea and crackling rales over the lung bases. She was placed in an oxygen tent and given aminophylline intravenously. Her respiratory distress continued, although it improved for short periods with symptomatic treatment. On the morning of her sixth hospital day the abdominal findings were much improved: She was less distended and the tenderness on the right side of the abdomen had practically disappeared. However, she still had fullness and tenderness on the left side and bowel sounds were still absent.

Her dyspnea continued, her pulse was 140, and she had diffuse rales and rhonchi over both lungs. A 500 cc. phlebotomy was done and was followed by moderate relief lasting approximately an hour. Thereafter she became quite incoherent and her temperature went to 103° F. She remained in respiratory distress, became irrational and died on her seventh hospital day.

Clinical Discussion

Dr. Wilson: This patient came in with a chief complaint of acute abdominal pain of three days' duration. She had had many operations in her younger years, and as you go a little bit further with her history you get some clues as to why she had so much surgery. For many years she had suffered from episodes characterized by left frontal headache with occasional photophobia followed by nausea and vomiting. This sort of thing makes you think of brain tumor or a congenital aneurysm, but most of you think first of a migraine syndrome with a persistent abdominal component.

Closely related to it symptomatically is a condition known as biliary dyskinesia, which is explained as some autonomic imbalance in the biliary physiology. These people have right upper quadrant pain, often with nausea and vomiting, and often with migraine headaches. One may take his choice: One may call this biliary dyskinesia with headaches or migraine with a biliary component, or look for some organic disease.

It is clear that her doctors were impressed with her symptoms since they took out her gallbladder at the age of 24. There aren't many things for which you take out the gallbladder at that age. Probably the commonest condition is cholelithiasis with serious attacks or hemolytic syndromes. If the latter are serious enough, about 60 per cent develop gallstones in their early twenties and require cholecystectomy. In the old typhoid days young people used to get gallstones commonly. Nowadays gallstones at the age of 24 are rather uncommon.

Ten Years Later

And ten years later she had another laparotomy and you can bet your bottom dollar that she was complaining of another abdominal pain with nausea and vomiting. They only found many adhesions, which is not surprising. She had not menstruated since the age of 36, but about the time of menopause migraine patients either get a whole lot worse or frequently much better.

Three weeks prior to her admission she was hospitalized for similar complaints and I presume that means nausea, headache and vomiting. Something happened apparently at about the time of her barium enema because for the first time she commenced having stools with blood and mucus. It would be nice to know whether she was passing a lot of blood and mucus or whether she was dribbling a little bit of mucus as people often do with proctitis. From now on things went from bad to worse. She left that local hospital feeling vaguely unwell, and then four days prior to admission here she developed this severe low abdominal noncramping pain.

We are going to lay great emphasis on the noncramping character and the fact that it was both front and back, in the lower abdomen, and radiating through to the lumbar and sacral area. It caused much distress, sleeplessness, nausea and vomiting. She had not been eating since food intake was associated with exacerbation of the pain. The vomitus was clear and not bloody.

Now on physical examination she appeared badly dehydrated and rather cyanotic. The abdomen was diffusely distended and the bowel sounds were hypoactive. She was tender to deep palpation. I am not sure why she had this more marked tenderness over the upper quadrants unless perhaps it was associated with muscle tenderness due to her protracted vomiting.

Her laboratory tests showed a leukocytosis, a normal serum amylase, and normal electrolytes. She had 3 plus sugar and a positive acetone in her urine, and in view of a blood sugar of 110 mg. I am willing to call this a stress glycosuria and think that her acetone was probably due to her protracted vomiting. Her x-ray examination showed her abdomen filling with fluid and some of her intestines distended with gas and fluid.

Her hospital course went from bad to worse. The pain remained unchanged. She was treated with narcotics and analgesics. Her temperature rose and she developed a paralytic ileus. The surgical consultant declined to intervene because of the patient's general condition, and an abdominal paracentesis yielded some serosanguineous fluid which had an amylase content below the levels significant of acute pancreatitis.

Now it is apparent at this point that the patient was losing blood somewhere. In spite of her dehydration she was dropping her hemoglobin, had a low hematocrit, and about this time or soon afterwards she became jaundiced. So we have to consider here the possibility that she was either hemolyzing her blood or that she was bleeding into the bowel and/or into the peritoneum. We know that some blood was being lost into the peritoneum because of the serosanguineous paracentesis fluid, and we might postulate that these bloody stools were much more voluminous than we had suspected heretofore. She also developed quite a marked leukocytosis, and it took 3 units of whole blood to bring her hemoglobin back up to 10.6 Gm.

Thirst

She remained quite tender in the abdomen and complained of thirst. I suspect that hypochloremia may be the reason for her thirst. As you know, you can fill people full of water and if their chloride level or their sodium level is low they will still be thirsty.

On the fifth day she seemed to improve a little bit but then had an acute attack of respiratory distress. It may have been that she was on the verge of congestive failure, perhaps due to a lot of parenteral fluid, and we see that fairly commonly whenever we keep on pouring in the fluids. We think we are using due caution, we listen to the lung bases, and then suddenly it becomes apparent that the patient's lungs are full of fluid. That happens more frequently than we like to admit. Then there is the possibility that she formed an embolus or developed a pulmonary thrombosis.

At any rate she was markedly congested and developed a cardiac type of asthma only temporarily relieved by aminophylline and a venous section. In spite of all these efforts the respiratory distress continued and we can suggest of course that she had a silent coronary attack with congestive failure. On the morning of the sixth hospital day the abdominal findings were improved for a time. She was less distended but she still had a silent abdomen, she was still short of breath and had tachycardia. She suddenly developed one of these acute phenomena which are associated with ruptured heart, ruptured aorta or a massive embolus. She suddenly tensed up, went into a spasm and expired.

But I am going to follow my original hunch and state that this woman had migraine with abdominal complaints. The surgeons fell for it and took her gallbladder out and then did another exploratory laparotomy, but her serious illness developed later.

Thrombosis

I think first and foremost I will suggest mesenteric vascular thrombosis, and we have the choice of whether it was arterial or venous. I think we are more conscious of arterial thrombi because they are almost always associated with easily recognizable cardiac disease leading to embolization or with extensive arteriosclerosis. This woman had neither. This woman was having bloody stools and several days later commenced to have abdominal pain. Now the insidiousness of this is more consistent with a venous thrombosis than with an arterial thrombosis. That I think could account for serosanguineous exudate, the fluid in the unaffected part of the bowel, and her downhill course, and the only thing we must explain is why she should have developed a venous thrombosis. I find no good reason for it and anything that I suggest is going to have to be purely imaginative.

We could conjure up a story for a perforated viscus here. She had a scarred duodenum. She might have had a comparatively asymptomatic ulcer. She had so many abdominal complaints that a lot of things could be readily missed. I don't think she had a perforated viscus or ulcer because she had no air in the abdomen, and I think that on paracentesis they would have found a purulent peritonitis instead of a serosanguineous peritonitis.

The physicians thought about pancreatic disease, and recurrent pancreatitis could account for a lot of her abdominal complaints. But we are confronted with all these normal amylase determinations. You could think of a bowel obstruction on the basis of old operative adhesions. This is a very important point, but I was taught by some excellent gastroenterologists that until proven otherwise adhesions don't cause bowel obstruction. In any large gastrointestinal service you will find patients with their bellies looking like a battlefield, who are being operated upon again and again to relieve the adhesions caused by the previous surgery. But there are exceptions and this patient may have had a partial obstruction that we all missed. She certainly could have had postoperative adhesions; goodness knows she had enough operations.

Enlarged Spleen

I am going to pass up abdominal aneurysm and retroperitoneal abscesses or lymphoma despite the enlarged spleen I can't account for. As far as metabolic disease is concerned, I don't think she had diabetes mellitus. Most of you have seen persons in diabetic ketosis who have serious abdominal pain and have died from having had a laparotomy when their diabetic ketosis was not recognized. Again many patients are operated on for pains of acute intermittent porphyria, which I don't believe this woman had.

So I am unable to explain the diagnosis of mesenteric thrombosis except to think of something which seems completely unfounded and for which we have not a single good argument. I am going to say that she suffered from a primary cancer of the tail of the pancreas and that the thrombogenic factor associated with this disease was responsible for her mesenteric thrombosis.

Clinical Diagnosis

1. Abdominal migraine.
2. Multiple operations with abdominal adhesions.
3. Mesenteric vein thrombosis with infarction of bowels and paralytic ileus.
4. Acute congestive failure.
5. Carcinoma of tail of pancreas.

Pathological Diagnosis

1. Portal vein thrombosis.
2. Thrombosis of splenic and mesenteric veins.
3. Multiple postoperative adhesions.
4. Infarction of the jejunum.
5. Infarction of the spleen.

Pathological Discussion

Dr. von Haam: The peritoneal cavity contained about 600 cc. of a hemorrhagic ascitic fluid. There were numerous fibrous adhesions between the bowel, the liver and the parietal peritoneum. The heart was normal, and the lungs showed atelectasis and acute congestion. The spleen weighed 575 grams and showed multiple infarcts. The splenic veins were thrombosed. The esophagus and stomach appeared normal. Sixty-two inches of the small bowel distal to the ligament of Treitz were deeply discolored, distended, and filled with dark red blood. All veins were thrombosed and the thrombi also extended in the large superior mesenteric vein, the portal vein and the liver. The colon was distended and filled with thin, black fecal material. The retroperitoneal and pelvic organs appeared normal.

Microscopic Examination

Microscopic examination showed thrombi in the portal vein and the mesenteric veins which already had begun to organize and were probably 6 to 10 days old, together with many more recent thrombi. Some of the vessel walls showed a very mild inflammatory reaction. The wall of the small intestine showed the typical picture of venous infarction with severe submucosal hemorrhage and less extensive mucosal necrosis. The liver and kidneys showed toxic degeneration. The pancreas was perfectly normal.

In summary then, the autopsy confirmed Dr. Wilson's principal diagnosis of mesenteric vein thrombosis with infarction of the bowels and paralytic ileus. The cause of the thrombosis appeared to be dense adhesions extending to and surrounding the portal vein from the ligament of Treitz, and the thrombotic process was a slowly progressive one involving more and more vessels as the days passed. The blood loss Dr. Wilson mentioned could be explained by hemorrhage into the lumen of the infarcted bowel.

The patient's respiratory distress was partly due to atelectasis caused by a high diaphragm, partly due to toxic shock with circulatory failure and pulmonary edema. Adhesions do not often embarrass the portal circulation, and it may be that a temporary volvulus, no longer recognizable at autopsy, started the whole process off. Once started, it progressed and spread until a large portion of the mesentery and intestines was involved, causing paralytic ileus, hemorrhagic peritonitis and fatal toxemia.

APPLICATION FOR SPACE, SCIENTIFIC AND EDUCATIONAL EXHIBIT, OHIO STATE MEDICAL ASSOCIATION, 1959 ANNUAL MEETING, VETERANS MEMORIAL BUILDING, COLUMBUS, O., APRIL 21-24

1. Title of Exhibit:

2. Name(s) of Exhibitor(s):

Institution (if desired):

City

3. Description of Exhibit: **(Attach 200 word description to this blank)**

4. Exhibit will consist of the following: (Check which)

Charts and posters Photographs Drawings X-rays

Specimens Moulages Other material
(Describe)

5. Booth Requirements:

Length of back wall needed?

Square feet needed?

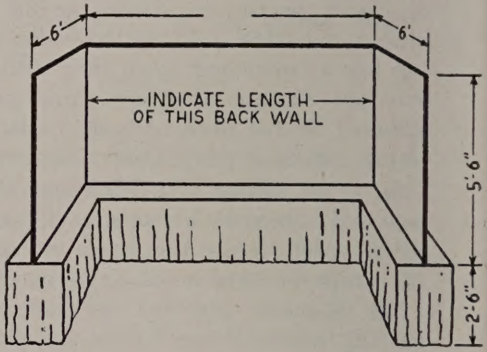
Shelf desired? (yes or no)

6. Transparency Cases:

Needed? (yes or no)

If answer "yes," give following information:

Number of transparencies to be shown and size of each



Booths will have a back wall and two side walls. The side walls of all booths will be six feet wide. Back wall and side walls are eight feet high. If standard shelf is used, only 5½ ft. will be available for exhibit material. For most exhibits, a back wall, eight feet long will be sufficient. With the two 6 ft. long side walls, this gives a total of 110 square feet of wall space.

(It is suggested that transparencies should be no larger than 10 by 12 inches in order to conserve space. For size of view boxes which will be supplied by the Ohio State Medical Association if requested by you and how films should be mounted, see pages 3 and 4 of folder "Regulations and Information, Scientific and Educational Exhibit, Ohio State Medical Association."

Date

Signature of Applicant

Mailing Address, Street

City, Zone, State

SEND APPLICATION TO: COMMITTEE ON SCIENTIFIC AND EDUCATIONAL EXHIBITS, OHIO STATE MEDICAL ASSOCIATION, 79 EAST STATE STREET, COLUMBUS 15, OHIO

Preview of 1959 Annual Meeting . . .

Event Will Be Coordinated with 125th Anniversary Celebration of the OSU College of Medicine; Unique Scientific Program Is in the Making

TWO outstanding events of 1959 will be coordinated to give Ohio physicians a unique and outstanding program. These events are the Annual Meeting of the Ohio State Medical Association and the 125th Anniversary Celebration of the Ohio State University College of Medicine. The dates are April 21-24, 1959, with most program features in the Veterans Memorial Building, Columbus.

Dr. Charles A. Doan, dean of the OSU College of Medicine, has named a special committee to work with the State Association's Committee on Scientific Work in arranging the program.

This and other committees of the OSU College of Medicine Celebration are named later in this article. The OSU College of Medicine 125th Anniversary Celebration will continue into Saturday, April 25. Events on that day will be on the OSU Campus.

Another event that will add interest to the Annual Meeting program is additional coordination of the program with meetings of the Ohio State Heart Association and the Ohio Division of the American Cancer Society. These organizations are holding programs on Tuesday, April 21. Scientific and Technical Exhibits of the Annual Meeting will be open on that day as well as on Wednesday, Thursday and Friday.

Here is a gist of the four-day program arranged in chronological order:

TUESDAY, APRIL 21

8:30 A.M.

Registration opens.

9:00 A.M.

Opening of exhibits.

9:30 to 11:00 A.M.

General Session.

Program to be sponsored by the Ohio Division, American Cancer Society.

11:00 to 11:30 A.M.

Recess for tour of exhibits.

11:30 A.M. to 12:30 P.M

Continuation of program.

2:00 to 3:00 P.M.

General Session.

Program to be sponsored by the Ohio State Heart Association.

General Session.

Program to be sponsored by the Ohio Division, American Cancer Society.

3:00 to 3:30 P.M

Recess for tour of exhibits.

3:30 to 5:00 P.M.

Continuation of programs.

WEDNESDAY, APRIL 22

8:30 A. M.

Registration.

9:00 A.M.

Opening of exhibits.

9:30 to 11:00 A.M.

Section meetings:

- Combined session of the Section on General Practice, Section on Internal Medicine and Section on Surgery.
- Section on Ophthalmology.
- Section on Nervous and Mental Diseases.
- Section on Urology.

11:00 to 11:30 A.M.

Recess for tour of exhibits.

11:30 A.M. to 12:30 P.M.

Continuation of section meetings listed above.

2:00 to 3:00 P.M.

General Session.

3:00 to 3:30 P.M.

Recess for tour of exhibits.

3:30 to 5:00 P.M.

General Session.

7:30 P.M.

Annual Banquet.

THURSDAY, APRIL 23

8:30 A.M.

Registration.

9:00 A.M.

Opening of exhibits.

9:30 to 11:00 A.M.

Section meetings:

- Combined session of Section on Pediatrics and Section on Physical Medicine.
- Combined session of Section on Anesthesiology and Section on Obstetrics and Gynecology.
- Combined session of Section on Otorhinolaryngology and Section on Radiology.
- Section on Neurological Surgery.
- Section on Industrial Medicine.

11:00 to 11:30 A.M.

Recess for tour of exhibits.

11:30 A.M. to 12:30 P.M.

Continuation of section meetings listed above.

2:00 to 3:00 P.M

General Session.

(Continued on Next Page)

(Continued from Preceding Page)

3:00 to 3:30 P.M.

Recess for tour of exhibits.

3:30 to 5:00 P.M.

General Session.

FRIDAY, APRIL 24

8:30 A.M.

Registration.

9:00 A.M.

Opening of exhibits.

9:30 to 11:00 A.M.

General Session.

Program to be presented by the faculty and alumni of Ohio State University College of Medicine as part of College's 125th Anniversary.

11:00 to 11:30 A.M.

Recess for tour of exhibits.

11:30 A.M. to 12:30 P.M.

Continuation of General Session.

2:00 to 3:00 P.M.

General Session.

Program to be presented by the faculty and alumni of Ohio State University College of Medicine.

3:00 to 3:30 P.M.

Recess for tour of exhibits.

3:30 to 5:00 P.M.

Continuation of General Session program.

5:00 P.M.

Adjournment.

OSU Committees Named

Here are the committees announced by Dr. Charles A. Doan, dean of the College of Medicine, in connection with the 125th Anniversary of the College and the OSMA Annual Meeting:

Steering Committee — Cyril T. Surington, M. D., Chairman, President, Medical Alumni Association; Robert J. Murphy, M. D., Secretary, Medical Alumni Association; Thomas E. Rardin, M. D., President-Elect, Medical Alumni Association; Charles A. Doan, M. D., Ex-officio; Richard L. Meiling, M. D., Ex-offico.

Scientific Program of the OSMA—125th OSU College of Medicine Anniversary Joint Program—April 24, 1959—Dr. Robert M. Zollinger, Chairman; Dr. Zeph J. R. Hollenbeck, Dr. Samuel Saslaw, Dr. Miner W. Seymour, Dr. Dwight M. Palmer, Dr. N. Paul Hudson, Ex-officio.

Committee on 25-Year History for the 125th Anniversary and Medical Alumni Reunion—Dr. N. Paul Hudson, Chairman and Editor-in-Chief; Dr. Linden F. Edwards, Dr. Chauncey D. Leake, Dr. Jonathan Forman, Dr. Rollo C. Baker, Dr. B. K. Wiseman, Dr. Earl H. Baxter, Dr. Philip J. Reel, Dr. John W. Means, Dr. William N. Taylor, Dr. Russell G. Means.

125th Anniversary Celebration—Friday Night Banquet—Dr. Robert J. Murphy, Chairman; Dr. Clark P. Pritchett, Mr. John B. Fullen, Dr. Rollo C. Baker, Miss Mildred E. Newton, Mr. Frederick Stecker, Medical Student Representative, Nursing Student Representative.

Alumni Day Program, April 25, 1959—Dr. Ernest W. Johnson, Chairman; Dr. Clark P. Pritchett, Dr. Cyril T. Surington, Dr. Robert J. Murphy.

American College of Physicians Announces Series of Courses

The American College of Physicians has announced a series of postgraduate courses to be held at various places. Additional information may be obtained by writing to the college at 4200 Pine Street, Philadelphia, Pa. Courses scheduled in the near future are the following:

Congenital Heart Disease, November 17-22, the Johns Hopkins Hospital, Baltimore; Dr. Helen B. Taussig, director.

Internal Medicine — Especially Therapeutics, January 12-16, University of Illinois College of Medicine, Chicago; Dr. Harry F. Dowling, director.

Current Research in Endocrinology, February 2 - 4, National Institutes of Health, Bethesda, Maryland.

Recent Advances in Cardiovascular Diseases, February 9-13, Mount Sinai Hospital, New York City; Dr. Charles K. Friedberg, director.

Recent Advances in Internal Medicine, February 23-27, Pennsylvania Hospital, Philadelphia, Pennsylvania.

Medical Assistants Society Plans 1959 Meeting, May 1, 2, 3

At a recent meeting of the board of directors of the Ohio State Society of Medical Assistants in Cincinnati, arrangements for the 1959 annual meeting of the society were discussed. The meeting will be at the Netherland-Hilton Hotel, Cincinnati, May 1, 2, and 3.

Plans were initiated to draft a "model" constitution and by-laws for local societies which can be used by the local societies as a guide for revising their constitution and by-laws or by those meeting to form a new medical assistants society.

It was voted that all local societies should work on a fiscal year from May 31 to June 1, the same as the fiscal year of the state society.

Proceedings of The Council . . .

Heavy Docket Handled at Granville Meeting; Committee Reports Received; New and Simplified Insurance Blank Will Be Distributed

THE Fall meeting of The Council was held at the Granville Inn, Granville, Ohio, September 12, 13, 14, 1958. All members of The Council were present except Dr. Robert E. Hopkins, Coshocton, Councilor of the Seventh District. In addition to the officers and Councilors the following AMA delegates attended: Dr. Charles L. Hudson, Cleveland; Dr. C. C. Sherburne, Columbus; Dr. L. Howard Schriver, Cincinnati; and Dr. Paul A. Davis, Akron. Also attending, by invitation, were Dr. Robert E. Reiheld, Orrville, chairman of the Committee on Rural Health; Dr. Frederick P. Osgood, Toledo, chairman of the Committee on Public Relations and Economics; Dr. Merrill D. Prugh, Dayton, Ohio chairman, American Medical Education Foundation; Dr. Anthony Ruppersberg, Columbus, chairman of the Committee on Maternal Health; Mr. Charles H. Coghlan, Columbus, executive vice-president of Ohio Medical Indemnity, Inc. Others present were Mr. Wayne E. Stichter, Toledo, legal counsel, and members of the staff of the Columbus office.

By official action, The Council approved the minutes of the meetings of The Council held on June 7 and 8, 1958.

Membership Data

The Executive Secretary reported on membership matters as follows: OSMA membership as of September 10, 1958—9,079; compared to a total membership of 9,070 members as of December 31, 1957. Members of the OSMA affiliated with the AMA as of September 10, 1958—8,072; compared to a total of 8,030 who were 1957 AMA members.

Pro-Rating and Waiver of Dues

By official action, The Council approved the following policy applying to pro-rating and waiver of dues for the calendar year 1959:

"1. **Pro-rating of dues for new regular members:** Dues for new members affiliating during the last six months of the calendar year 1959, namely, July 1 to December 31, inclusive, shall be $12.50. Pro-rating of dues shall not apply to former members re-affiliating.

"2. Annual Ohio State Medical Association dues for a physician serving a hospital internship or residency during the first five years following graduation from medical school (excepting the time spent in military service), who meets the membership eligibility requirements of the Ohio State Medical Association and who is accepted into membership by a component medical society, shall be $7.50. Such intern or resident member shall be offered a subscription to *The Ohio State Medical Journal* at one-half the regular subscription rate.

"3. The following procedure shall apply with respect to OSMA annual dues of members on extended active duty in the military service or in the United States Public Health Service:

"1. State Association dues for 1959 shall be waived for members on extended active duty in the military service or U. S. Public Health Service.

"2. State Association dues for 1959 shall be waived for physicians who were members of the Association in 1958 and who enter such services during the calendar year 1959 before the payment of 1959 dues.

"3. A refund of membership dues will not be made if a member enters such services in 1959 after his 1959 dues are received at the Columbus Office of the Association.

"4. The secretary-treasurer of each county medical society shall be requested to cooperate with the Columbus Office in assembling the names of physicians entitled to waiver of dues under the foregoing provisions."

Social Security Poll

The Council approved the procedure outlined for a poll of the membership on the question, "Should physicians be included in the Federal Social Security Program?", such poll to start October 1 and to end October 31. The Council, by official action, authorized the President to appoint a committee of tellers for this project. Dr. Woodhouse appointed as tellers Doctors Robert M. Inglis, Perry R. Ayres and Philip B. Hardymon of Columbus to work with the Columbus Office staff on this detail.

Additional Office Space Rented

On recommendation of the Executive Secretary, The Council considered enlarging the Columbus Office by renting space adjoining the present offices in the Hartman Theater Building, available on or about October 1. After due consideration, The Council **authorized** the rental of the additional space.

Resignation of Dr. Jonathan Forman as Editor

The Council then went into executive session at which The Council was advised by Dr. Woodhouse that he, President-Elect Mayfield and Past-President Martin had conferred on last August 3 with Dr. Jonathan Forman, editor of *The Ohio State Medical Journal,* with regard to the increasing confusion and misunderstanding which have developed because of the conflict between the publicly expressed views of Dr. Forman, opposing fluoridation of public water supplies and the official pronouncements of the Ohio State Medical Association favoring fluoridation.

Dr. Woodhouse reminded The Council that this same question had been discussed with Dr. Forman at a meeting of The Council last December.

Dr. Woodhouse advised The Council that Dr. Forman at the August 3 conference said he would submit his resignation as editor of *The Journal* to The Council at the Granville meeting on September 13-14.

The Council then considered a lengthy written statement from Dr. Forman in which he reviewed his views on fluoridation and his activities in opposition to fluoridation. In the statement he offered to resign as editor of *The Journal* if The Council considered such action advisable.

After a discussion in detail by all members of The Council, **Dr. Forman's resignation was accepted to become effective October 15, 1958, and the following statement adopted:**

"It is the belief of The Council that officials and employees are obligated to refrain from advocating in public statements on public questions, policies that are at variance with the official views of the organization. If one feels that he must pursue an opposite course, he should divorce himself from his official position.

"The Council's action is not in any sense of the word an attempt to censure Dr. Forman because his views on fluoridation differ from those expressed in the official policy of the Ohio State Medical Association.

"The Council defends the right of any person to think and believe as he pleases. Also, it defends the right of an individual **who is not an official or employee** of this Association to make public statements on any subject, even though such statements may be at variance with the Association's official position.

"The Council desires to express to Dr. Forman, on behalf of the Ohio State Medical Association, sincere thanks for his long and competent services as Editor of *The Ohio State Medical Journal.* The high standing which *The Journal* has attained is tangible evidence of the outstanding job which he has done for the membership of the Association."

Those who voted in the negative on the motion to accept Dr. Forman's resignation were: Doctors Dooley, Gustafson, Monger and Pease.

A motion to make the vote unanimous was then voted on. Those voting in the negative were: Doctors Dooley and Pease.

By official action, The Council then authorized the President to appoint a committee to interview prospects for the position of editor of *The Journal* and to report back to Council. Dr. Woodhouse named Dr. Mayfield, Dr. Martin and himself.

Belmont County Amendments

Following the executive session, The Council considered certain amendments which are to be voted upon by the Belmont County Medical Society. On the advice of Mr. Stichter and the Executive Secretary, The Council tentatively approved such amendments. It instructed the Executive Secretary to advise the Belmont County Medical Society that The Council will officially approve such amendments after their adoption by the Belmont County Medical Society.

Mahoning County Amendments

Consideration was given to lengthy amendments adopted by the Mahoning County Medical Society. These had been reviewed by Mr. Stichter, legal counsel, and the Executive Secretary as well as Dr. Gustafson, Councilor of the Sixth District. It was pointed out by them that there appeared to be a large number of questionable items in the amendments and it was their recommendation that The Council not act on all of the amendments at this meeting.

By official action, The Council **approved** amendments adopted by the Mahoning County Medical Society to existing Article 4 of the present Constitution of the society and amendments to existing Chapter 4 of the present By-Laws of the society. Such action was taken so the society could use the new provisions in electing officers, councilors and delegates for 1959.

By official action, **action was delayed** on the rest of the amendments submitted by the Mahoning County Medical Society and Mr. Stichter was instructed to prepare a memorandum of recommendations to be submitted to the Mahoning County Medical Society for its consideration.

Revised Constitutions and By-Laws Approved

The Council, by official action, then **approved** revised constitutions and by-laws submitted by the Pickaway County Medical Society, having been adopted by that society on August 1, 1958, and the Huron County Medical Society, having been adopted by that society on March 12, 1958.

1959 Conference of County Society Officers and Committeemen

The Council selected the date Sunday, February 22, 1959 for the annual conference of county society presidents, secretaries and committeemen at the Deshler Hilton Hotel, Columbus. It instructed the Executive Secretary to extend an invitation to Dr. Julien P. Price, Florence, South Carolina, vice chairman of the Board of Trustees of the AMA to be a luncheon guest speaker at the February 22 meeting.

1959 Annual Meeting

The Council then, by official action, **approved** the plans drafted by the Committee on Scientific Work for the 1959 Annual Meeting in Columbus, April 21-24, inclusive. (See Pages 1465-1466 for schedule of events.)

By official action, The Council **selected Cincinnati** for the 1963 Annual Meeting the week of April 21.

There was a discussion of the honorarium paid to out-of-state guest speakers on the annual meeting program. By official action, The Council **authorized** the payment of $100.00 honorarium, in addition to expenses, starting with the 1959 Annual Meeting.

New OMI Contract

The Council then received a lengthy report from Dr. R. Dean Dooley, Dayton, Councilor of the Second District and chairman of the executive committee of Ohio Medical Indemnity, Inc., regarding a new and more liberal contract which has been developed by the Board of Directors of OMI and which will be placed on sale in the near future. After a general discussion by Dr. Dooley, Mr. Coghlan, executive vice-president of OMI, and individual members of The Council, The Council accepted the report by Dr. Dooley and officially commended the Board of Directors of OMI for having developed the new and more liberal contract. **(See pages 1478-1482 for detailed story.)**

Assignment Forms

A communication from a physician, advocating that Ohio Medical Indemnity pay physicians direct or attach an assignment blank to the report form filed by a contract holder, was discussed by The Council. Reference was made to the official action of the House of Delegates of the Ohio State Medical Association on this question at the 1956 Annual Meeting. Such action opposed payment of physicians direct and opposed the attachment of the blank routinely to report forms, but did approve payment by OMI jointly to a subscriber and a physician in cases where a properly executed assignment form is attached to the claim form filed by such subscriber. It was the opinion of The Council that The Council would have no authority to take any action contrary to the action taken by the House of Delegates in 1956.

Report of Cancer Committee

The Council then received a report from the Committee on Cancer.

In the report the committee pointed out that it would be highly desirable, both from an ethical and legal standpoint, if some legislation could be enacted to make either cancer alone or cancer and other non-communicable diseases reportable to the Ohio Department of Health so there would be no ethical or legal problem involved when physicians make such reports either to a cancer registry or to other agencies specified by law or regulation. Specifically, the committee **recommended** that The Council give consideration to sponsoring legislation along these lines.

After a lengthy discussion, The Council felt that it should have additional information on this matter before acting. Therefore, by official action, The Council **postponed action** on this recommendation so that additional information could be assembled for review by The Council.

Report of Committee on School Health

A report for the Committee on School Health was given by Mr. Page due to the absence of Dr. Thomas E. Shaffer, Columbus, chairman of that committee, because of the death of his father. The Council, by official action, expressed sympathy to Dr. Shaffer and requested the Executive Secretary to convey this message to him.

Mr. Page reported on the Fifth Ohio Conference on Physicians and Schools, held April 29, 30, and May 1, at Lake Hope, and on behalf of the State Planning Committee for Health Education thanked The Council for continued financial support of the Conference by the Ohio State Medical Association. He announced that six other associations and agencies assisted in making the 1958 Conference possible.

Mr. Page announced that the Committee on School Health will sponsor an exhibit at the annual Ohio Congress of Parents and Teachers in Cincinnati, October 6, 7 and 8.

Mr. Page also said that he would appear before the State Board of Control and the District Boards of the Ohio High School Athletic Association to discuss with them ways in which the Ohio State

Medical Association could promote and assist programs on athletic injuries, sponsored in cooperation with county medical societies.

He announced that assistance had been provided to the Health Teacher Training Sessions at Kent State University and Ohio State University during the summer. The report was **accepted and approved** by The Council.

Report of Committee on Poison Control

Mr. Page presented a report on behalf of the Committee on Poison Control and discussed the committee's report verbally.

By official action, The Council **approved** all parts of the report with the exception of a suggestion that the OSMA support legislation on uniform labeling. This part of the report was held over for future consideration in view of the fact that the committee is now holding conferences with other groups on this subject.

Report of Judicial and Hospital Relations Committees

Dr. Orr presented a report on behalf of the Committee on Hospital Relations and the Committee on Judicial and Professional Relations, based on a joint conference on August 10 with members of the professional relations committee of the Ohio Hospital Association.

The opinions expressed by the two OSMA committees in their joint report, reading in part as follows, **were approved** by The Council by official action: (1) Questions presented by the hospital association committee can be adjudicated through application of the "Joint Statement of Basic Principles for Guidance of Ohio Physicians and Ohio Hospitals" and the recently-adopted statement of The Council of the Ohio State Medical Association entitled, "Statement Regarding Unauthorized Practice of Medicine by Partnerships, Associations, Institutions, Corporations, Unlicensed Persons and the Ethical Status of Physicians Involved." Both statements are excellent guides to local arrangements which may be made without violation of the law prohibiting the corporate practice of medicine. Therefore, legislation is not necessary.

(2) The committees believe if amendments to the Medical Practice Act with respect to internships, licensing of foreign graduates, control of unlicensed and irregulars, etc., suggested by the hospital association, should become necessary, these matters should be discussed with representatives of the State Medical Board and other interested parties before any definite plans are made for proposed amendments to the Medical Practice Act. It was the sense of the committees that the need for amendments to the act as suggested by the hospital association committee has not been shown.

(3) It is the belief of the committees that an educational program among members of the Association should be carried on with respect to the recently-adopted Statement of Policy on Corporate Practice.

The Council also adopted a motion commending the two committees for their excellent work during the past year, especially with regard to the drafting of the official statement of policy on the unauthorized practice of medicine by corporations, et al., which was officially adopted by The Council on June 8, 1958.

Report of Committee on Public Relations and Economics

Dr. Frederick P. Osgood, Toledo, Chairman, submitted a report on a meeting of the Committee on Public Relations and Economics held on August 3. He and Mr. Saville discussed the report verbally.

Selection of Board of Health

Part 1 of the report dealt with action on Resolution No. 16 at the 1958 Annual Meeting, calling for a study of possible legislation to change the method of selection of members of district boards of health. The committee has been requested by The Council to make such a study. Reference was made to a conference with representatives of the Butler County Medical Society which had sponsored the resolution. Also, reference was made to studies which had been made in recent years to this subject. Dr. Osgood reported that the committee by unanimous vote had requested the Butler County Medical Society to present to the committee for future consideration, concrete suggestions for changes in the law designed to accomplish the objectives of the resolution.

By official action The Council **approved** this portion of the report.

Medical Care of Migrant Workers

Dr. Osgood reported that his committee had met with representatives of the Wood County Medical Society with regard to Resolution No. 17 at the 1958 Annual Meeting, asking for a solution to the problem of paying physicians for medical services to migrant laborers and their dependents. He stated that it was the consensus of the committee that: (1) experience has proved that voluntary insurance, as a solution to this problem, has proved impractical elsewhere because of the shifting tenure of the migrant worker's employment, difficulty of enrollment, and apathy on the part of the workers and employers; (2) the requirement that one particular type of employer, namely, employer of migratory workers, be compelled by law to carry health insurance on these workers would be discriminatory and contrary to the Association's policy in opposition to compulsory health insurance.

Dr. Osgood advised The Council that the committee unanimously voted to ask the Wood County Medical Society to formally request the county commissioners and the county welfare department to assume responsibility for the medical and hospital care of migrant laborers who are unable to pay for such care themselves, and further, that the Wood County Medical Society advise the committee of the reaction to such request.

He reported further that the committee also instructed the State Headquarters staff to initiate discussions with representatives of the Governor's Committee on Migrant Labor, the Ohio Department of Public Welfare, and any other groups which may be concerned in meeting this problem.

By official action The Council **approved** this portion of the report.

Simplified Insurance Forms

His committee reviewed the reaction of the Health Insurance Council to the proposed simplified insurance form for Ohio, which the committee tentatively approved at its meeting October 6, 1957, and subsequently transmitted to the Health Insurance Council for comment, Dr. Osgood reported.

He said the committee approved several changes in the proposed form in order to meet some of the objections raised by the Health Insurance Council.

By unanimous action, Dr. Osgood stated his committee recommended to The Council that arrangements be made to make a statewide simplified insurance form, drafted by the committee, available to members to be used by them if they wish in lieu of other forms which they consider too complicated.

In making this recommendation, the committee expressed the hope that local county medical societies which are now using their own insurance forms will adopt the OSMA-approved form and that it will have general usage throughout the state.

It was also brought out in the committee discussion, Dr. Osgood said, that while there is no guarantee that all insurance companies will accept the OSMA-approved claim form in all cases, it is the hope of the committee that this simplified form will eventually be widely accepted by most insurance companies.

The Council by official action **approved this part of the report and the insurance form referred to.** (Information about the new blank will be published in a later issue of *The Journal* after details have been worked out.)

Laboratories Survey

The final portion of the report of the Committee on Public Relations and Economics related to the report of a Subcommittee on Laboratory Services which had made a survey of hospital and clinical laboratories of the state and the recommendations of the subcommittee.

Dr. Osgood reported that the main committee had approved the report of the subcommittee, with the recommendation that if The Council authorizes the appointment of a Committee on Laboratory Medicine, as recommended, that this committee also be requested to continue the study of methods for the improvement of laboratory services in order to, as fully as possible, accomplish the intent of Resolution E concerning the matter of establishing qualifications and standards for diagnostic laboratories, passed at the 1957 session of the House of Delegates.

The Council **officially approved** this part of the report. **(See page 1493 for report and recommendations of Subcommittee on Laboratories.)**

Then, by official action, The Council **approved** the report and recommendations of the Committee on Public Relations and Economics as a whole and commended the committee on a fine report and constructive recommendations.

By separate action, The Council also **adopted** a motion commending the special laboratory committee, which had been headed by Dr. Horace B. Davidson, Columbus.

Report of Committee on Rural Health

The report of the Committee on Rural Health was presented by Dr. Robert E. Reiheld, Orrville, chairman of the committee. It was discussed verbally by him and Mr. Edgar, secretary of the committee. Dr. Reiheld reported that Glenn D. Hisrich, Stone Creek, O., Route 1, had been awarded the 1958 OSMA Rural Medical Scholarship, and informed the Council of the status of the nine previous winners.

He reported that the 1959 lectures to medical students at the three medical schools in Ohio all would be one-day programs since a test of this plan last February showed attendance considerably increased over the once-a-week lectures. He said the committee's second annual preceptorship program enabled 17 University of Cincinnati medical seniors spending two weeks with rural or small

(Continued on Page 1474)

The Achievements of Arist

...in Skin Diseases: In a study of 26 patients with severe dermatoses, ARISTOCORT was proved to have potent anti-inflammatory and antipruritic properties, even at a dosage only ⅔ that of prednisone[1]... Striking affinity for skin and tremendous potency in controlling skin disease, including 50 cases of psoriasis, of which over 60% were reported as *markedly improved*[2]...absence of serious side effects specifically noted.[1,2,3]

...in Rheumatoid Arthritis: Impressive therapeutic effect in most cases of a group of 89 patients[4]... 6 mg. of ARISTOCORT corresponded in effect to 10 mg. of prednisone daily (in addition, gastric ulcer which developed during prednisone therapy in 2 cases disappeared during ARISTOCORT therapy).[5]

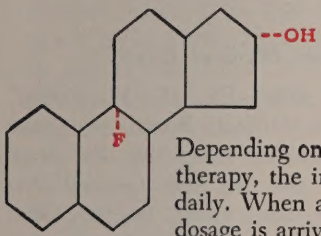
1. Rein, C. R., Fleischmajer, R., and Rosenthal, A. L.: J. A. M. A. *165*:1821, (Dec 7) 1957.
2. Shelley, W. B., and Pillsbury, D. M.: Personal Communication.
3. Sherwood, A., and Cooke, R. A.: Personal Communication.
4. Freyberg, R. H., Berntsen, C. A., and Hellman, L.: Paper presented at International Congress on Rheumatic Diseases, Toronto, June 25, 1957.
5. Hartung, E. F.: Personal Communication.
6. Schwartz, E.: Personal Communication.
7. Sherwood, A., and Cooke, R. A.: J. Allergy 28:97, 1957.
8. Hellman, L., Zumoff, B., Kretshmer, N., and Kramer, B.: Paper presented at Nephrosis Conference, Bethesda, Md., Oct. 26, 1957.
9. Ibid.: Personal Communication.
10. Barach, A. L.: Personal Communication.
11. Segal, M. S.: Personal Communication.
12. Cooke, R. A.: Personal Communication.
13. Dubois, E. L.: Personal Communication.

ocort®

Triamcinolone LEDERLE

...in Respiratory Allergies: "Good to excellent" results in 29 of 30 patients with chronic intractable bronchial asthma at an average daily dosage of only 7 mg.[6] . . . Average dosage of 6 mg. daily to control asthma and 2 to 6 mg. to control allergic rhinitis in a group of 42 patients, with an actual reduction of blood pressure in 12 of these.[7]

...in Other Conditions: Two failures, 4 partial remissions and 8 cases with complete disappearance of abnormal chemical findings lead to characterization of ARISTOCORT as possibly the most desirable steroid to date in treatment of the nephrotic syndrome.[8,9] . . . Prompt decrease in the cyanosis and dyspnea of pulmonary emphysema and fibrosis, with marked improvement in patients refractory to prednisone.[10,11,12] . . . Favorable response reported for 25 of 28 cases of disseminated lupus erythematosus.[13]



Depending on the acuteness and severity of the disease under therapy, the initial dosage of ARISTOCORT is usually from 8 to 20 mg. daily. When acute manifestations have subsided, maintenance dosage is arrived at gradually, usually by reducing the total daily dosage 2 mg. every 3 days until the smallest dosage has been reached which will suppress symptoms.

Comparative studies of patients changed to ARISTOCORT from prednisone indicate a dosage of ARISTOCORT lower by about ⅓ in rheumatoid arthritis, by ⅓ in allergic rhinitis and bronchial asthma, and by ⅓ to ½ in inflammatory and allergic skin diseases. With ARISTOCORT, no precautions are necessary in regard to dietary restriction of sodium or supplementation with potassium.

ARISTOCORT is available in 2 mg. scored tablets (pink), bottles of 30; and 4 mg. scored tablets (white), bottles of 30 and 100.

Lederle LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK

(Continued from Page 1471)

town general practitioners, and efforts are being made to include Ohio State University and Western Reserve University in the program.

Nearly 80,000 4-H Personal Health Records have been distributed to 4-H boys and girls in the past 18 months, and county 4-H health improvement contest winners have been awarded subscriptions to *Today's Health*, Dr. Reiheld stated. The boy statewide contest winner will be given $75 to aid in his expenses in attending the National 4-H Club Congress in Chicago next December.

Council voted **to accept** the report and to commend the committee for its activities.

Report of Committee on Traffic Safety

A brief report was submitted by the Executive Secretary on behalf of the Traffic Safety Committee. It was pointed out that the committee has been cooperating with the Department of Highway Safety and the Cornell Crash Injury Research Program. Mr. Nelson also pointed out that a large majority of the county medical societies have appointed Traffic Safety Committees as requested by the OSMA committee. He pointed out that the committee will meet again in the near future to devise a program of activities on a short-term and long-term basis.

The report was **officially approved.**

Report of Maternal Health Committee

Dr. Ruppersberg, Chairman of the Committee on Maternal Health, presented on behalf of his Committee, the Ohio Maternal Mortality Study covering the year 1955.

The Council **approved the report,** with special commendation to the Committee and to the physicians who cooperated in securing information for the study. **(See pages 1458-1459 for text of report.)**

Perinatal Mortality Studies in Ohio Approved

A committee representing the Ohio Chapter, American Academy of Pediatrics, appeared before The Council to discuss a proposal that perinatal mortality studies be inaugurated in all Ohio hospitals by the physicians of such hospitals participating in obstetrical and newborn services. Those presenting the subject to The Council were: Dr. J. Victor Greenebaum, Dr. Carl J. Ochs and Dr. Arthur King, Cincinnati; Dr. Edward V. Turner and Dr. James Williams, Columbus; and Dr. Robert Morrison, Zanesville. They discussed several pilot studies which have been made throughout the state and suggested that The Council give serious consideration to approving the idea of asking all hospitals to inaugurate such studies.

By official action, The Council **approved** the project which is to be sponsored by the Ohio Chapter, American Academy of Pediatrics, in cooperation with other organizations, and commended the Academy for this program.

Medicare Program

Mr. Nelson presented a report on the present status of the Medicare Program, based on a meeting held in Washington on August 8 which he attended on behalf of the Association and on official directives received since that meeting with respect to a severe cutback in the program. He referred to a detailed article which will appear in the October 1 issue of *The Ohio State Medical Journal* on this subject.

Fall Pre-Election Conferences

Mr. Saville reported on plans which have been completed for the Fall pre-election conferences in the 11 Councilor Districts during the week of September 15.

November 4 Election

The Council discussed thoroughly the two issues which will be on the ballot at the November 4 election proposing amendments to the Ohio Constitution, namely, the so-called "Right To Work" proposal and the county government charter proposal. It was the opinion of The Council that no official action should be taken on these proposals inasmuch as neither involves a medical or health question and that it would be up to each individual physician to decide for himself as a voter and citizen as to whether he favors either or both proposals.

Request from Medical Board

A communication from Dr. H. M. Platter, Secretary of the State Medical Board, was read and discussed. The letter stated that the State Medical Board will ask the next General Assembly to adopt an amendment to the Ohio Medical Practice Act increasing the fee for examination from $25.00 to $50.00 and the fee for endorsement from $50.00 to $100.00. The letter pointed out that the income from the Board from all sources amounts to approximately $43,000 annually, which is less than the expenditures necessary for the Board. It is the opinion of the Medical Board that more adequate appropriations for the Board can be secured from the Legislature providing there is an increase in the revenue paid into the general fund by the Board. The communication asked the active support of the Ohio State Medical Association. By official action, The Council voted **to actively support** a change in the

Medical Practice Act as outlined in the communication from the Board.

OSMA Group Life Insurance Program

A report from Turner and Shepard, Inc., Columbus, regarding the OSMA group life insurance program was presented and considered by The Council. The report pointed out that 940 physicians and 294 employees of physicians, a total of 1,234 were enrolled for the basic coverage as of September 9. It was pointed out in the report that after a September 18 deadline for state-wide annual enrollment, enrollment would be open for a period of 60 days in certain Councilor Districts. Assistance of the Councilors on the re-enrollment programs by districts was requested. The report stated that the underwriting company, Union Central of Cincinnati, has agreed that all applicants in a Councilor District will be issued the basic insurance without evidence of insurability if 50 per cent of the members in the district enroll, including those already enrolled.

American Medical Education Foundation

Plans for the 1958 campaign in behalf of the American Medical Education Foundation were presented by Dr. Merrill D. Prugh, chairman of the Ohio AMEF committee, and by Mr. Saville.

Dr. Prugh discussed the vital importance of additional private support of medical schools. He reminded members of The Council that as members of the Ohio AMEF Committee it is their responsibility to stimulate interest in AMEF in their respective councilor districts.

Mr. Saville reported that contributions from Ohio physicians to AMEF and directly to the Alumni Funds of medical schools reached an all-time high in 1957. Donations to AMEF amounted to $33,141.87 from 717 donors. A total of $132,566.56 was contributed by 3,646 Ohio physicians directly to medical schools, making a grand total of $165,708.43 from 4,363 contributors. He pointed out that the AMEF total included $10,682.34 raised through various projects by the Woman's Auxiliaries, for which they received national recognition.

The Council **accepted the report** and thanked Dr. Prugh for his interest in this important activity.

Workmen's Compensation Fee Schedule

The Executive Secretary presented a report on action by the Bureau of Workmen's Compensation with respect to certain increases in the Medical and Surgical Fee Schedule effective October 1. A memorandum on the changes in the fee schedule was presented to The Council for its information. It was pointed out that the Bureau did not approve recommendations of the OSMA in their entirety but did accept most of the recommendations in part. Mr. Nelson stated that an article on this matter has been prepared and will be published in the October issue of *The Ohio State Medical Journal.*

By official action, The Council **expressed its appreciation** to the Bureau of Workmen's Compensation for having accepted part of the recommendations of the Association, even though some of the increased fees which become effective October 1 do not appear to be compatible with present economic conditions.

Request from Internists

A request from the Ohio Society of Internal Medicine that a provision similar to certain sections of the Medicare Fee Schedule covering services of internists be included in the fee schedule covering the Veterans Administration Hometown Care Program in Ohio, was considered. By official action, The Council **decided** to suggest to the Veterans Administration that it include special fees for services of internists in the Ohio V. A. Fee Schedule to be effective at the beginning of the next fiscal year, namely, July 1, 1959.

Iowa Public Relations Plaque

A request from an advertising company in Des Moines, Iowa, that the Ohio State Medical Association sponsor the sale of a public relations plaque similar to the one used by the Iowa State Medical Society, was discussed. By official action, The Council felt that this project should not be undertaken at this time.

Report on AMA House of Delegates

Dr. Charles L. Hudson, Cleveland, gave a detailed report on sessions of the House of Delegates held in connection with the San Francisco meeting of the AMA in June, 1958. His report was supplemented by comments from other Ohio delegates to the AMA present at this meeting.

Control of Staphylococcal Disease

A communication from the Ohio Department of Health, asking the Association to send an official representative to a regional conference on control of staphylococcal disease in hospitals, in Chicago on October 10, was discussed. By offcial action, The Council **approved** the sending of an official representative to the conference.

Plaque for Out-Going Councilors

During that period of the meeting devoted to reports by Councilors a motion was adopted authorizing the preparation of a certificate or plaque which would be presented by the Association to all Councilors terminating office under the constitutional provision placing a three-term limit on Councilors, such recognition to start with the 1959 Annual Meeting.

The Council, having completed its business, then **adopted by a rising vote** a motion to adjourn in honor of the following former officers and Councilors who have died during the past year: Dr. Clyde L. Cummer, Cleveland, Dr. Harry V. Paryzek, Cleveland, and Dr. Ralph L. Rutledge, Alliance, former presidents; and Dr. James R. Jarvis, Van Wert, Dr. Guy E. Noble, St. Marys, and Dr. Emmett B. Shanley, New Philadelphia, former Councilors.

Attest: CHARLES S. NELSON,
Executive Secretary.

Cincinnati Fund To Provide Appliances For the Medically Indigent

Establishment of a special fund to provide the medically indigent with prosthetic appliances and special medicines has been announced by Dr. Bernard A. Schwartz, Cincinnati, president of the Max, Martha and Alfred M. Stern Fund for Special Medicines and Appliances.

Initial contributions aggregate a sum of $100,000.00 with $25,000.00 immediately available for use by the Fund. Mr. Murray Seasongood, brother of the late Martha Seasongood Stern, and Mrs. Seasongood made the fund possible.

Dr. J. Robert Hudson, incoming president of the Academy of Medicine of Cincinnati, will be the official representative of the Academy on the executive committee of the fund. Dr. Schwartz is chairman of the executive committee of the Stern Fund. Other members are Murray Seasongood, Jeanette P. Long, Agnes Seasongood, Mary H. Beckjord, Dr. Carl A. Wilzbach and Dr. Hudson.

General Physicians Promote Radiology Course Series

The Southwestern Ohio Society of General Physicians in collaboration with the University of Cincinnati College of Medicine is presenting a series of courses on radiology. The programs are held on Tuesday mornings from 9:00 to 11:00 a. m. under direction of Dr. Benjamin Felson, professor and director of the Department of Radiology. Secretary of the program committee for the SOSGP is Dr. Gaston B. Hannah. The seminar began on October 14 and will run through January 27.

Hospital Disaster Planning References Listed

Following are excerpts from a report of the Hospital Disaster Planning Committee of the Ohio Hospital Association:

In studying the list of hospitals which do not have disaster plans, the committee has noted that most are in the 100 beds or less group. Many of these are in one-hospital communities where the obligation is particularly heavy in time of disaster. The following references have been selected to be of assistance to the hospitals of the group:

Experiences in the Handling of a Disaster in a Small Hospital, by Paul E. Campbell, M. D., and Robert M. Jones, *Hospital Management,* June 1957—Vol. 83.

How a Small Hospital Has Prepared, *The Canadian Hospital,* March 1955—Volume 32.

85 Bed Hospital is Equal to 400 Victims, by Ralph M. Haas, *The Modern Hospital,* June 1958—Vol. 90.

Role of the Medical Staff in Emergency Service, Mass Casualty Handling, by James H. Irwin, *Hospitals, J. A. H. A.,* July 1957, p. 54 Vol. 31.

Readings in Disaster Planning for Hospitals, *A. H. A.,* 1956.

Preparation for Local Disaster, *Manual of Disaster Planning for the Hospitals of Ohio.*

Principles of Disaster Planning for Hospitals, 1956.

If copies of these periodicals are not accessible directly, they may be obtained from the American Hospital Association Library, 18 East Division Street, Chicago 10, Illinois.

The Ohio Hospital Association also maintains a series of portfolios containing a large number of disaster plans of other Ohio Hospitals of all sizes. The purpose of these portfolios is to provide examples which will assist the individual administrators in creating plans that will meet the particular needs of their hospital.

Obstetrics and Gynecology

The Part I Examinations of the American Board of Obstetrics and Gynecology, are to be held in various parts of the United States and Canada, on Friday, January 16, 1959, at 2:00 p. m. Current Bulletins outlining present requirements may be obtained by writing to the Secretary's office, Robert L. Faulkner, M. D., American Board of Obstetrics and Gynecology, 2105 Adelbert Road, Cleveland 6, Ohio.

Comments by investigators on

Robaxin®

(Methocarbamol Robins, U.S. Pat. No. 2770649)

Robins

–the remarkably efficient skeletal muscle relaxant, unique in chemical formulation, and outstanding for sustained action and relative freedom from adverse side effects.

PUBLISHED REFERENCES: 1. Carpenter, E. B.: Southern Medical Journal 51:627, 1958. 2. Forsyth, H. F.: J.A.M.A. 167:163, 1958. 3. Little, J. M., and Truitt, E. B., Jr.: J. Pharm. & Exper. Therap. 119:161, 1957. 4. Morgan, A. M., Truitt, E. B., Jr., and Little, J. M.: J. Am. Pharm. Assn., Sci. Ed. 46:374, 1957. 5. O'Doherty, D. S., and Shields, C. D.: J.A.M.A. 167:160, 1958. 6. Park, H. W.: J.A.M.A. 167:168, 1958. 7. Truitt, E. B., Jr., and Patterson, R. B., Proc. Soc. Exper. Bio. & Med. 95:422, 1957. 8. Truitt, E. B., Jr., Patterson, R. B., Morgan, A. M., and Little, J. M.: J. Pharm. & Exper. Therap. 119:189, 1957.

Supply: Tablets (white, scored), 0.5 Gm., bottles of 50 and 500.

A. H. ROBINS CO., INC., Richmond 20, Va.

Ethical Pharmaceuticals of Merit since 1878

Summary of four new published clinical studies:

Robaxin Beneficial in 95.6% of Cases of Acute Skeletal Muscle Spasm[1, 2, 5, 6]

CONDITION	NO. PATIENTS	RESPONSE			
STUDY 1[1]		"marked"	moderate	slight	none
Skeletal muscle spasm secondary to acute trauma	33	26	6	1	—
STUDY 2[2]		"pronounced"			
Herniated disc	39	25	13	—	1
Ligamentous strains	8	4	4	—	—
Torticollis	3	3	—	—	—
Whiplash injury	3	2	1	—	—
Contusions, fractures, and muscle soreness due to accidents	5	3	2	—	—
STUDY 3[5]		"excellent"			
Herniated disc	8	6	2	—	—
Acute fibromyositis	8	8	—	—	—
Torticollis	1	—	—	1	—
STUDY 4[6]		"significant"			
Pyramidal tract and acute myalgic disorders	30	27	—	2	1
TOTALS	138	104 (75.3%)	28 (20.3%)	4	2

THE JOURNAL of the American Medical Association

"In the author's clinical experience, methocarbamol has afforded greater relief of muscle spasm and pain for a longer period of time without undesirable side effects or toxic reactions than any other commonly used relaxants . . ."[2]

THE JOURNAL of the American Medical Association

"An excellent result, following methocarbamol administration, was obtained in all patients with acute skeletal muscle spasm."[5]

THE JOURNAL of the American Medical Association

"In no instance was there any significant reduction in voluntary strength or intensity of simple reflexes."[6]

Southern Medical Journal

"This study has demonstrated that methocarbamol (Robaxin) is a superior skeletal muscle relaxant in acute orthopedic conditions."[1]

New Ohio Medical Indemnity Contract . . .

More Liberal Schedules of Indemnities and New Coverages Offered; Big Job To Exchange This for Old Contracts Emphasized by OMI Officials

OHIO MEDICAL INDEMNITY, Inc., the Ohio Blue Shield Plan, is making available on November 1, 1958, a new and more liberal contract.

The increasing number of expressions of dissatisfaction from subscribers and physicians with regard to the indemnities which were paid by Ohio Medical, particularly involving the Standard Contract, prompted the Board of Directors to authorize a state-wide survey of current charges for medical services.

This new contract, developed as a result of the survey, not only approaches the current level of physicians' charges, but also includes new coverages not heretofore offered by Ohio Medical.

Big Sales Job Ahead

An outline of the new contract was presented to The Council of the Ohio State Medical Association at its September, 1958, meeting by Dr. R. D. Dooley, chairman of the OMI Executive Committee.

Dr. Dooley pointed out that this more comprehensive coverage **will not immediately replace existing contracts, as it will take some time to effect this exchange of contracts.** Nevertheless, it was felt that Ohio Medical should have this contract available now for those groups that wish to purchase a contract providing indemnity payments more closely related to current physicians' charges, he told The Council.

In a statement to *The Journal* regarding the new contract, Dr. H. M. Clodfelter, president of Ohio Medical Indemnity, emphasized how important it will be for Ohio physicians to actively promote the purchase of the more liberal contract by all subscriber groups at the earliest possible time.

Hope To Cover All Eventually

"At present Ohio Medical has about 748,000 Standard Contracts and about 160,000 Preferred Contracts outstanding," Dr. Clodfelter said. "Obviously, the hope of OMI officials is that all these contracts will be converted eventually to the new contract which has just been adopted. Also, obviously, it will be a big job to convince all of the many groups of subscribers that they should have the better coverage offered under the new contract. Doctors can help a lot on this, by talking up the new contract among their Blue Shield patients and recommending to them that their group convert to the new contract at the earliest possible time."

Speakers For County Medical Societies

Members of the Board of Directors of Ohio Medical have expressed a willingness to attend meetings of County Medical Societies and hospital staff meetings to discuss the new contract and answer questions concerning it. Requests for OMI speakers should be sent to Mr. Charles H. Coghlan, executive vice-president, Ohio Medical Indemnity, 3770 N. High Street, Columbus.

Commenting on the necessity for explanation of the new contract to physicians, Dr. George A. Woodhouse, President of the Ohio State Medical Association, stated he hoped that all County Medical Societies will take advantage of this offer of OMI directors.

"It would be fine if each County Medical Society would arrange to devote a meeting in the near future to a discussion of this new OMI contract and OMI activities in general," Dr. Woodhouse said. "Members of the OMI board are familiar with the contract and therefore quite competent to explain it in detail. As physicians become more familiar with the contract, they will become enthusiastic about promoting it, I am sure. We don't expect doctors to be OMI salesmen but we do hope that they will be OMI boosters which is only accomplishing the same thing in a different way."

Mr. Coghlan has announced that a brochure giving details about the new contract will be ready soon for distribution to the medical profession.

Surgical Anesthesia Section of Contract

The Surgical-Anesthesia Section of the contract will provide a higher schedule of indemnities for surgical procedures with a maximum payment of $450. This new surgical schedule is in line with present average charges in Ohio for surgical services.

The anesthesia coverage has been revised and will provide payments as high as $75 for some of the major surgical procedures.

Samples of New Contract

Here are some samples and examples of the indemnities of the Surgical-Anesthesia Section of the new contract:

*The asterisk indicates that local anesthesia is customarily administered and that no indemnity is payable. If general anesthesia is required and administered in such instances, the amount of the indemnity, if any, will be determined by Ohio Medical Indemnity.

	Surgical Indemnity	Anesthesia Indemnity
Integumentary System		
Skin and Subcutaneous Areolar Tissue		
Incision and drainage of infected steatoma, furuncle or small subcutaneous abscess	$ 15.00	*
Local excision of small benign neoplastic lesion	25.00	*
Excision of pilonidal cyst or sinus	125.00	$ 25.00
Burns or Skin Grafts	Amount of indemnity to be determined by Ohio Medical	
Suturing of wound or wounds within twenty-four (24) hours after accident	Amount of idemnity to be determined by Ohio Medical	
Breast		
Excision of cyst, fibroadenoma or other benign tumor, aberrant breast tissue, duct lesion or nipple (including any other partial mastectomy):		
unilateral	75.00	25.00
bilateral	100.00	25.00
Complete mastectomy, simple:		
unilateral	125.00	25.00
bilateral	175.00	30.00
Radical mastectomy	275.00	60.00
Musculoskeletal System		
Fractures		
Clavicle: simple	50.00	*
compound or open operation	100.00	25.00
Scapula: simple	50.00	*
compound or open operation	100.00	25.00
Rib: simple strapping	25.00	*
Humerus: simple	100.00	*
compound or open operation	200.00	35.00
Radius, head or shaft: simple	75.00	*
compound or open operation	150.00	30.00
Radius, distal end Colles'; simple	75.00	*
compound or open operation	150.00	30.00
Ulna, shaft: simple	75.00	*
compound or open operation	150.00	30.00
Radius and Ulna, shafts: simple	100.00	25.00
compound or open operation	150.00	30.00
Phalanx: simple	25.00	*
compound or open operation	50.00	20.00
Femur: simple	250.00	30.00
compound or open operation	350.00	50.00
Tibia, shaft: simple	100.00	20.00
compound or open operation	150.00	30.00
Fibula, shaft: simple	75.00	*
compound or open operation	100.00	25.00
Tibia and Fibula, shaft: simple	125.00	30.00
compound or open operation	200.00	40.00
Dislocations		
Temporomandibular, closed reduction	25.00	10.00
Clavicle: closed reduction	75.00	25.00
open reduction	250.00	45.00
Shoulder (humerus), closed reduction	75.00	25.00
Knee (tibia), closed reduction	100.00	25.00
Ankle, closed reduction	75.00	25.00
Amputations		
Disarticulation of shoulder	350.00	60.00
Arm through humerus	150.00	30.00
Forearm, through radius and ulna	150.00	30.00
Disarticulation of wrist	150.00	30.00
Hand through metacarpal bones	150.00	30.00
Finger, any joint or phalanx	50.00	20.00
Thigh, through femur, including supracondylar	250.00	45.00
Leg, through tibia and fibula	200.00	40.00
Toe, any joint or phalanx	50.00	20.00
Respiratory System		
Septectomy: submucous resection	150.00	30.00
Maxillary sinusotomy, simple; antrum window operation	50.00	*
Maxillary sinusotomy, radical	150.00	30.00
Ethmoidectomy, intranasal	100.00	*
Bronchosocopy:		
diagnostic, with or without biopsy	75.00	10.00
with removal of foreign body	125.00	20.00
Total Pneumonectomy	450.00	75.00
Lobectomy, total or subtotal	450.00	75.00
Cardiovascular System		
Ligation and division of saphenous vein and branches at saphenofemoral junction, with or without retrograde injection,		
unilateral	100.00	35.00
bilateral	150.00	35.00
Complete radical removal of entire great saphenous system,		
unilateral	175.00	45.00
bilateral	225.00	45.00
Cardiac catheterization	100.00	*
Valvulotomy	450.00	75.00
Digestive System		
Tonsillectomy, with or without adenoidectomy	65.00	20.00
Esophagoscopy:		
diagnostic, with or without biopsy	75.00	10.00
operative including removal of foreign body	150.00	20.00
Total gastrectomy	400.00	75.00
Pyloroplasty	200.00	40.00
Gastrojejunostomy or gastroduodenostomy	250.00	40.00
Enterectomy, resection of small intestine	250.00	45.00
Colectomy: resection of large intestine, all or part, one or more stages	300.00	50.00
Excision of Meckel's Diverticulum	150.00	30.00
Appendectomy	150.00	30.00
Fistulotomy or fistulectomy	125.00	25.00
Incision and drainage of ischiorectal abscess	50.00	20.00
Fissurectomy, with or without sphincterotomy	50.00	20.00
Hemorrhoidectomy:		
Internal, or internal and external	125.00	25.00
Internal with fissure	140.00	25.00
Internal with fistula	160.00	25.00
Cholecystectomy	250.00	40.00
Exploratory laparotomy	150.00	25.00
Herniotomy, inguinal or femoral:		
unilateral	150.00	30.00
bilateral	200.00	40.00

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	Surgical Indemnity	Anesthesia Indemnity
Urinary System		
Pyelolithotomy	300.00	50.00
Nephrectomy	300.00	60.00
Nephropexy: fixation or suspension of movable kidney	200.00	40.00
Cystoscopy:		
diagnostic, initial	50.00	20.00
subsequent (maximum of four)	20.00	10.00
Cystoscopy:		
with stone removal and ureteral dilation or with fulguration of bladder tumor, initial	100.00	25.00
subsequent (maximum of four)	20.00	10.00
Ureterolithotomy	225.00	40.00
Male Genital System		
Circumcision: 31 days to 12 years of age	15.00	*
age 12 or over	60.00	25.00
Orchiectomy	100.00	25.00
Excision of hydrocele	100.00	20.00
Prostatectomy, one or more stages, complete or partial	300.00	35.00
Female Genital System		
Excision or cautery destruction of Bartholin's gland or cyst	75.00	25.00
Repair of cystocele	125.00	30.00
Repair of rectocele	125.00	30.00
Repair of cystocele and rectocele	175.00	30.00
Salpingectomy	150.00	30.00
Salpingo-oophorectomy	150.00	30.00
Oophorectomy	150.00	30.00
Hysterectomy (with or without dilation and curettage and surgery on tubes, ovaries, ligaments, etc.):		
Panhysterectomy; total hysterectomy (corpus and cervix); Supracervical hysterectomy; sub-total hysterectomy	250.00	40.00
Radical hysterectomy for cancer (Wertheim)	350.00	65.00
Vaginal hysterectomy, with or without pelvic floor repair	250.00	40.00
Amputation of cervix	125.00	30.00
Dilation and curettage of uterus	65.00	20.00
Hysteropexy (with or without surgery on tubes, ovaries, etc.)	150.00	30.00
Endocrine System		
Thyroidectomy, complete or partial, total or subtotal	250.00	45.00
Hemithyroidectomy: lobectomy	250.00	45.00
Excision of thyroglossal duct, cyst or sinus	200.00	35.00
Nervous System		
Trephination (or burr holes) exploratory	150.00	40.00
Laminectomy	400.00	75.00
Excision of brain cyst, neoplasm or abcess	450.00	75.00
Sympathectomy: cervical or lumbar	250.00	50.00
Drainage of subdural hematoma	400.00	75.00
Eye		
Enucleation of eyeball (bulb or globe), with or without implantation of prosthesis	200.00	40.00
Probing of lacrimonasal duct	25.00	20.00
Extraction of lens, intracapsular or extracapsular	250.00	*
Myotomy, tenotomy, recession, resection, advancement or shortening of ocular muscles for strabismus, one or more stages:		
unilateral	175.00	30.00
bilateral	200.00	30.00
Excision of chalazion	25.00	*
Ear		
Myringotomy	15.00	*
Fenestration of semicircular canals	400.00	75.00
Mobilization of stapes	225.00	40.00
Obstetrics		
Obstetrical delivery	50.00	None
Caesarean section	200.00	30.00
Caesarean section and hysterectomy (Porro)	250.00	40.00
Removal of extra-uterine embryo (ectopic pregnancy) by laparotomy	200.00	30.00
Miscarriage or abortion, before period of viability (no surgery)	25.00	*
Miscarriage or abortion, including dilation and curettage	65.00	20.00
Dilation and curettage of uterus for postpartum bleeding	65.00	20.00

In-Hospital Medical Services Section

The contracts of Ohio Medical Indemnity, Inc., currently provide for a per diem method of paying for in-hospital medical services. The survey mentioned previously revealed that this per diem method resulted in the overpayment to some subscribers, particularly the long-stay cases, and the underpayment to other subscribers, most often those who were acutely ill and received an extraordinary amount of medical care in a relatively short stay.

The new contract will continue to provide per diem payments of $10 for the first day; $5 for each of the next three days of each hospital confinement; $4 a day thereafter up to a total of 30 days.

Patients remaining in the hospital beyond 30 days are eligible under the new contract for 90 additional days' coverage at $4 a day depending on the illnesses involved. Patients hospitalized for geriatric, chronic, convalescence or nervous and mental conditions will not be paid for more than 30 days' coverage. In addition to the above per diem payments, the new contract will provide a supplemental indemnity for serious cases requiring an extraordinary amount of medical care during the first few days of hospitalization, such as acute heart conditions, diabetic coma, etc. The supplemental payments—for services beyond the first 30 days in hospital and for serious cases requiring extraordinary medical care during the first few days—were designed to meet the inconsistencies disclosed in the survey and will be determined by Ohio Medical Indemnity through its Medical Advisory Committee.

Radiotherapy

The indemnity payments under the Radiotherapy Section of the contract are as follows:

An indemnity of $10 per treatment will be provided for deep x-ray therapy with a limit of fifteen treatments per year. Skin neoplasms treated with x-ray will be paid at $5 per treatment, with a limit of six treatments per year.

The payment for radium application to skin neoplasms will be $20 per treatment with a maximum of three treatments per year. Payment for radium treatment to other than skin neoplasms will be $75 per treatment with a maximum of two treatments per year. An indemnity will also be provided for the use of isotopes in the treatment of neoplasms.

New Benefit Added

A new benefit has been added under this section of the contract, namely, the provision of an indemnity for the therapeutic use of I^{131}. No indemnity will be paid for I^{131} uptake studies for diagnostic purposes.

Limited Diagnostic X-Ray and Laboratory Examinations

Two entirely new coverages are included in the new contract. Since Ohio Medical subscribers invariably have a companion Blue Cross contract providing x-ray and laboratory benefits for hospitalized bed patients, the new benefits are designed to idemnify the subscriber towards the cost of some diagnostic x-ray and laboratory procedures performed in a physician's office or in the out-patient department of a hospital. **All diagnostic x-ray and laboratory procedures could not be covered for actuarial reasons.** Only those x-ray and laboratory procedures listed in the contract will be covered.

Following are the indemnities in the new contract for diagnostic x-ray and laboratory examinations:

Diagnostic X-Ray Examination Indemnities

Mylography	$ 20.00
Eye for foreign body	12.00
Eye for localization of foreign body	20.00
Bronchogram	20.00
Fistula examination with contrast	12.00
Cholangiography, post operative	16.00

An indemnity will be provided as shown for the following examinations with a maximum payment of $40.00 per patient per contract year.

G. I. Tract—Complete (barium meal and barium enema), including gall bladder study	40.00
Esophagus, with contrast	12.00
Small bowel studies, with contrast	16.00
Upper gastro-intestinal tract, with contrast	20.00
Colon by barium enema	16.00
Colon by barium enema and double contrast	20.00
Gall bladder, cholecystography	16.00

An indemnity will be provided as shown for the following examinations with a maximum payment of $36.00 per patient per contract year.

Pyelography—intravenous	20.00
Pyelography—retrograde	16.00
Cystography	12.00
Urethrocystography	12.00

X-Ray Examinations, Accidents Only

If two or more of the following diagnostic x-ray examinations are conducted successively on account of injuries sustained in one accident, the total amount payable therefor shall be limited to the amount specified in the Schedule of Diagnostic X-ray Examination Indemnities for that examination, which has the greatest indemnity, plus one-half of that diagnostic x-ray examination which has the next greatest indemnity, plus one-half of the amount specified for that diagnostic x-ray examination which has the third greatest indemnity, providing the service is rendered within forty-eight (48) hours of an accident. No payment shall be made for more than three such examinations.

Shoulder	$ 8.00
Arm	8.00
Elbow	8.00
Forearm, including one joint	8.00
Wrist	8.00
Hand	8.00
Fingers	4.00
Hip, single film	8.00
Hip, complete, multiple positions	16.00
Femur, including one joint	8.00
Knee	8.00
Leg, including one joint	8.00
Ankle	8.00
Foot	8.00
Toes	4.00
Spine, cervical	12.00
Spine, thoracic	12.00
Spine, lumbo-sacral	12.00
Spine, sacro-coccygeal	12.00
Spine, lumbo-sacral, including pelvis and hips	12.00
Facial bones	8.00
Nasal bones	8.00
Skull	12.00
Mandible	8.00
Ribs	8.00

Laboratory Examination Indemnities

($50.00 maximum per patient per year)

Blood	Schedule of Indemnity
Antistreptolysin Titer	$ 6.00
Blood Culture, definitive	6.00
Bone Marrow, collection and interpretation	12.00
Bone marrow, interpretation	8.00
Bromsulphalein	5.00
Congo red, complete test	8.00
CO_2 content, arterial blood	7.00
Cholesterol esters	8.00
Complement Fixation Tests for Viruses	8.00
Creatine tolerance	16.00
Electrophoresis pattern, protein	8.00
" " lipoprotein	8.00
" " hemoglobin	8.00

(Continued on Next Page)

	Schedule of Indemnity
Hemoglobin, sulfhemoglobin quan.	8.00
Iron Binding Globulin saturation, serum	8.00
Oxygen saturation, arterial blood	7.00
Insulin Tolerance Test	12.00
L-E Test (Dog or Human Marrow)	8.00
Lead, serum or urine	12.00
Oxygen content, arterial blood	7.00
Oxycorticoids	12.00
Protein-bound Iodine	12.00
Sugar (Glucose) Tolerance, per specimen	3.00
Rh, complete	8.00
Urea Clearance	8.00
Vitamin A	8.00
Volume	8.00
Feces	
Culture, definitive	8.00
Gastric or Duodenal (Aspiration included)	
Chemical, acid, Fractional (histamine)	8.00
Culture for TB, Animal inoculation	12.00
Spinal Fluid	
Collection	6.00
Chemical Tests, serology, microscopic (including cell count, colloidal gold or gum mastic)	16.00
Culture for Bacteria, plus acid fast	8.00
Animal inoculation for Bacteria	12.00
Urine	
Quantitative Functional (Addis)	10.00
Porphyrins, quantitative	8.00
Culture, definitive	6.00
plus acid-fast	8.00
Animal inoculation	12.00
17-Ketosteroids	10.00
11-Oxysteroids	10.00
Gonadotropins	12.00
Pregnandiol	10.00
Estrogen Assay	12.00
17-Hydroxycorticoids	14.00
Miscellaneous	
Howard Test	16.00
Insulin, Complement Fixation	8.00
Mercury, urine	8.00
Semen, complete analysis	8.00
Cytology	
Papanicolaou Smear, only for gastric including collection	12.00
Surgical Pathology	
Class A—Surface biopsies of uncomplicated character not requiring special stains and certain surgical specimens as appendix, gallbladder, etc.	6.00
Class B—Surgical specimens of more complicated character such as lymph nodes, tumors of soft tissues, needle biopsies, etc.	8.00

Limitation on Total Payments

The new contract contains a provision that the payment to a subscriber shall not exceed the total costs incurred for physicians' services, subject to the maximum amounts specified in the schedules of indemnities.

Enrollment in Ohio Medical now stands at 2,255,000 members, making it the fourth largest Blue Shield plan in the United States. Payments to subscribers are currently averaging $1,600,000 per month.

General Practitioners of Franklin County Offer Fall Seminar

The Franklin County Academy of General Practice is presenting its Fall Seminar in Columbus on Friday, November 21, at the New Veterans Memorial Building. This is the day before the Ohio-Michigan game.

The seminar is approved for 5½ hours credit for General Practice members. Attendance will be limited to 150 members. Tuition for AAGP members is $15; for non-members, $20.00. Pre-registration should be sent to E. D. McCallister, M. D., 877 Mohawk St., Columbus 6, Ohio. For those who wish to leave early, the program will be over by 3:30. For those who wish to stay for the game, hotel reservations should be made with any of the Columbus leading hotels.

The program has been announced as follows:

8:30 a. m.—Registration.
9:00 —**Minor Surgery in the Office**, Dr. Warren Harding, Worthington.
9:30 —**Management of Eye Disorders**, Dr. Malcolm McCannel, Minneapolis, Minn.
10:15 —**Office Management of Acute and Chronic Ear Disorders**, Dr. Carl Roth, Columbus.
10:45 —Break.
11:00 —**Office Proctology**, Dr. Karl Zimmerman, Pittsburgh, Pa.
11:45 —Panel of Morning Speakers—Questions and Answers.
12:15 p. m.—Seafood Luncheon, Kit Carson, Columbus.
1:15 —**Office Anesthesia, Regional and Local**, Dr. Robert Smith, Circleville.
1:45 —Management of Injured Athlete on Playing Field, in Training Room and Office, Dr. Richard Patton, OSU Team Physician, Columbus.
2:25 —Break.
2:30 —**Office Management of Urologic Problems**, Dr. Hall Wiedemer, Mansfield.

Van Meter Prize Award

The American Goiter Association again offers the Van Meter Prize Award of $300.00 and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The award will be made at the annual meeting of the Association which will be held in the Drake Hotel, Chicago, Illinois, April 30, May 1 and 2, 1959.

Interstate Program in Cleveland Will Include Many Ohio Physicians

The Interstate Postgraduate Medical Association is sponsoring the Interstate 43rd International Medical Assembly at the Cleveland Public Auditorium and the Statler-Hilton Hotel, Cleveland, November 10 - 13.

A number of Ohioans are on the program. Following are topics to be discussed by Ohio physicians:

"Recent Pharmacologic Advances Applicable to Obstetrics and Gynecology," Dr. Allan C. Barnes, chairman of the Department of Obstetrics and Gynecology, Western Reserve.

"Cancer of the Breast," Dr. George Crile, Jr., head of the Department of General Surgery, Cleveland Clinic.

"The Treatment of Respiratory Emergencies," Dr. Jay Jacoby, director of the Department of Anesthesiology, Ohio State University.

Panel on "Diseases of the Pancreas," Dr. Robert M. Zollinger, chairman of the Department of Surgery, Ohio State; Dr. Edwin H. Ellison, professor of surgery, Marquette University (formerly of OSU); Dr. Dan W. Elliott, assistant professor of surgery, OSU; Dr. Stanley O. Hoerr, chairman, Division of Surgery, Cleveland Clinic; Dr. William D. Holden, professor of surgery, Western Reserve.

"Surgical Treatment of Persistent Symptoms Following Cholecystectomy," Dr. Zollinger.

"Medical and Surgical Problems in Liver Disease," Dr. William A. Altemeier, chairman, Department of Surgery, University of Cincinnati; Dr. Richard W. Vilter, director, Department of Internal Medicine, University of Cincinnati.

"Athletic Injuries and What To Do with Them," Dr. Richard Patton, clinical assistant professor of surgery, Ohio State.

"The Tired Mother Syndrome," Dr. Leonard L. Oovshin, Division of Medicine, Cleveland Clinic.

"Special Considerations Regarding Fractures in Children," Dr. Charles H. Herndon, associate professor of orthopedic surgery, Western Reserve.

"The Use of Diuretics in the Treatment of Hypertension," Dr. Hariet P. Dustan, Cleveland Clinic.

In addition, a number of Ohio physicians will present exhibits during the meeting, and others will participate in teaching demonstrations.

In the United States the number of married couples was almost 39 million in 1957, an increase of 37 per cent over the 1940 figure of 28.5 million.—*Metropolitan Life.*

Do You Know? . . .

OSMA President-Elect Frank H. Mayfield extended the convocation address to the freshman class of The Ohio State University College of Medicine September 29.

* * *

Dr. Richard W. Vilter, director of the Department of Internal Medicine, University of Cincinnati College of Medicine, recently went to Geneva, Switzerland, to participate in the World Health Organization's first study session on anemias. He reported on his research on the relationship between anemias and nutritional deficiency.

* * *

Recent visiting professor in the University of Cincinnati College of Medicine was Dr. Richard Shuman, Washington, D. C., chief of the Section on Soft Tissue Tumors at the Armed Forces Institute of Pathology.

* * *

Professor Chauncey D. Leake, assistant dean of the OSU College of Medicine, Columbus, presided at recent sessions of the American Society for Pharmacology and Experimental Therapeutics held at the University of Michigan, Ann Arbor. He also held informal discussions on teaching pharmacology to non-medical students.

* * *

Dr. E. Perry McCullagh, Cleveland, is the new president of the Endocrine Society, having been installed at the organization's annual meeting in San Francisco. He is head of the Department of Endocrinology and Metabolism at Cleveland Clinic.

* * *

The eleventh Henry B. Frieberg Memorial Lecture was given on October 21 in the School of Nursing auditorium, Jewish Hospital and Medical Center, Cincinnati. Lecturer was Dr. Felix Wroblewski, New York City, who discussed the subject of "Biochemical Biopsy Via Body Fluids."

* * *

Robert L. Richards, assistant director of The Medical Society of the State of Pennsylvania, has resigned that position in order to become Executive Secretary of the American Society of Internal Medicine with headquarters in San Francisco, the resignation effective December 31.

* * *

At a special meeting of the House of Delegates of the Oklahoma State Medical Association held on September 21, the House of Delegates voted to not continue participation in the Department of Defense's program for medical care for dependents of military personnel.

Barbiturate Control Act . . .

Ohio Has Strict Law on Distribution and Use of Barbiturate; Here Are High Points of the Law Including Restrictions, Keeping of Records, etc.

OHIO has a strict law in regard to barbiturate and every physician in practice should be thoroughly familiar with its provisions. The law is intended to crack down on illict use of the drug and imposes only enough restrictions on physicians to make it unpopular for them to be careless in prescribing or administering.

A previous article in *The Journal* detailed provisions of the Ohio Narcotics Control Act. Refer to pages 1366-1372, October, 1958, issue.

Following are excerpts of the Barbiturate Control Act:

Definitions

Sec. 3719.23. As used in sections 3719.23 to 3719.29, inclusive, of the Revised Code:

(A) "Barbiturate" means the salts and derivatives of barbituric acid, also known as malonyl urea, having hypnotic or somnifacient action, and compounds, preparations, and mixtures thereof.

(B) "Delivery" means sale, dispensing, giving away, or supplying in any other manner.

(C) "Patient" means either of the following:

(1) The individual for whom a barbiturate is prescribed or to whom a barbiturate is administered;

(2) The owner or the agent of the owner of the animal for which a barbiturate is prescribed or to which a barbiturate is administered.

(D) "Person" includes individual, corporation, partnership, and association.

(E) **"Practitioner" means a person licensed in this state to prescribe and administer drugs.**

(F) "Pharmacist" means a person registered with the state board of pharmacy as a compounder, dispenser, and supplier of drugs.

(G) **"Prescription" means a written order, and in cases of emergency, a telephonic order, by a practitioner to a pharmacist for a barbiturate for a particular patient, which specifies the date of its issue, the name and address of such practitioner, the name and address of the patient, and, if such barbiturate is prescribed for an animal, the species of such animal, the name and quantity of the barbiturate prescribed, the direction for use of such drug, and the signature of such practitioner.**

(H) "Manufacturer" means persons other than pharmacists who manufacture barbiturates, and includes persons who prepare such drugs in dosage forms by mixing, compounding, encapsulating, entableting, or other process.

(I) "Wholesaler" means persons engaged in the business of distributing barbiturates to persons included in any of the classes named in divisions (A) to (G), inclusive, of section 3719.25 of the Revised Code.

(J) "Warehouseman" means a person who stores barbiturates for others and who has no control over the disposition of such barbiturates except for the purpose of such storage.

Prohibition Against Delivery

Sec. 3719.24. No person shall:

(A) Deliver any barbiturate unless:

(2) **Such barbiturate is delivered by a practitioner in the course of his practice and the immediate container in which such drug is delivered bears a label on which appears the directions for use of such drugs, and the name and address of such practitioner, the name and address of the patient, and, if such drug is prescribed for an animal, a statement showing the species of the animal.**

(B) **Refill any prescription for a barbiturate unless so designated on the prescription by the practitioner.**

(C) Deliver a barbiturate upon prescription unless the pharmacist who filled such prescription files and retains it as required by division (B) of section 3719.26 of the Revised Code.

(D) Possess a barbiturate unless such person obtained such drug on the prescription of a practitioner or in accordance with division (A) (2) of this section or from a person licensed by the laws of any other state or the District of Columbia to prescribe or dispense barbiturates.

(E) Refuse to make available and to accord full opportunity to check any record or file as required by section 3719.27 of the Revised Code.

(F) Fail to keep records as required by divisions (A), (B), or (C) of section 3719.26 of the Revised Code.

(H) Obtain or attempt to obtain a barbiturate by fraud, deceit, misrepresentation, or subterfuge; or by the forgery or alteration of a prescription; or by the use of a false name or the giving of a false address.

Any practitioner who gives a prescription to a pharmacist by telephone shall give a written

prescription to such pharmacist within seventy-two hours after such telephone message.

Exceptions

Sec. 3719.25. Division (A) and (D) of Section 3719.24 of the Revised Code do not apply to the delivery of barbiturates to persons included in any of the classes named in this section, or to the agents or employees of such persons, for use in the usual course of their business or practice or in the performance of their official duties, or to the possession of barbiturates by the following persons or their agents or employees for such use:

(A) Pharmacists;

(B) Practitioners;

(C) Persons who procure barbiturates for disposition by or under the supervision of pharmacists or practitioners employed by them, or for the purpose of lawful research, teaching, or testing, and not for resale;

(D) Hospitals and other institutions which procure barbiturates for lawful administration by practitioners;

(E) Officers or employees of federal, state, or local governments;

(F) Manufacturers and wholesalers;

(G) Carriers and warehousemen.

Keeping of Records

Sec. 3719.26. (A) **Persons, other than carriers, to whom section 3719.25 of the Revised Code is applicable shall:**

(1) Make a complete record of all stocks of barbiturates on hand on August 12, 1949, and retain such record for not less than two calendar years immediately following such date;

(2) Retain each commercial or other record relating to barbiturates maintained by them in the usual course of their business or occupation, for not less than two calendar years immediately following the date of such record.

(B) Pharmacists shall, in addition to complying with division (A) of this section, retain each prescription for a barbiturate received by them, for not less than two calendar years immediately following the date of the filling or the date of the last refilling of such prescription, whichever is the later date.

(C) A practitioner shall, in addition to complying with division (A) of this section, keep a record of all such barbiturates administered, dispensed, or professionally used by him otherwise than by prescription, for not less than two calendar years immediately following the date of the last administering, dispensing, or professional use; such record shall give the name and address of the patient, but need not be kept when the amount administered, dispensed, or professionally used in the treatment of any one patient does not exceed twelve grains in any forty-eight consecutive hours.

Inspection of Files

Sec. 3719.27. Persons required by section 3719.26. of the Revised Code, to keep files or records shall, upon the written request of an officer or employee designated by the state board of pharmacy, make such files or records available to such officer or employee, at all reasonable hours, for inspection and copying, and accord to such officer or employee full opportunity to check the correctness of such files or records, including opportunity to make inventory of all stocks of barbiturates on hand. No person shall fail to make such files or records available or to accord such opportunity to check their correctness.

(I) Whoever violates sections 3719.23 to 3719.28, inclusive, of the Revised Code shall be fined not more than five hundred dollars or imprisoned not more than one year, or both.

A Recent Opinion of the Attorney General

The following opinion recently given by Attorney General William Saxbe is in regard to the care of a non-tuberculous patient in the Ohio Tuberculosis Hospital.

(1) When a patient admitted to the Ohio tuberculosis hospital under the provisions of Sec. 3701.63, R. C., is found not to have tuberculosis, but is continued temporarily in a patient status under the provisions of Sec. 3701.65, R. C., and the county of his residence is being reimbursed in full for the cost of his hospital care, such a patient is hospitalized under Secs. 3701.60 to 3701.64, inclusive, R. C., and the auditor of state is required to transmit to the board of county commissioners of such county a statement of the amount due for such care and treatment less a credit of one dollar and twenty-five cents per day as provided in Sec. 3701.64, R. C.

(2) Under the provisions of Sec. 3701.65, R. C., the county is required to pay the state the expenses of care and treatment of a non-tuberculous patient only when the county is being paid back in complete measure for such expense.

(3) The director of health has no authority to make a determination of how much of the per diem rate a non-tuberculous patient is able to pay and bill the county commissioners of the county of his residence for an amount less than the full charge for his care and treatment.—Opinion No. 2683.

Poison Control . . .

In Cooperation with Existing Facilities, OSMA Committee Studies Plans To Extend Services Available to Physicians Toward a State-Wide Program

THIS report of the Ohio State Medical Association's Committee on Poison Control was prepared by Dr. John A. Norman, Akron, the committee's chairman. Ohio has six poison information centers in operation. This report will bring readers up to date on what is being done to widen the field and coordinate efforts toward state-wide coverage.

* * *

For many years the problem of accidental ingestion of poisonous substances, particularly by children, has been a gradually increasing one recently compounded by the rapid advance in the variety and complexity of commercial products and their ready accessibility to children in the home. Physicians often find themselves confronted with a child who has swallowed a product the chemical properties or potential poisoning effect of which is unknown or uncertain.

In an attempt to solve this problem a number of metropolitan areas have established through their own local efforts a centralized point for information pertaining to various poisons and designated as a Poison Information Center. For several years physicians in a few Ohio cities have enjoyed the services of such locally operated poison information centers and have found them to be a workable method of reducing the guesswork in the treatment of potentially poisoned individuals. Many smaller communities have appreciated the need for a poison information center but the difficulties of establishing and effectively maintaining it is greater than their local resources can provide.

In order to bridge the gap and provide this service equally to all physicians, the Ohio State Medical Association has established a Committee on Poison Control to work out plans for extending this service to every physician practicing in Ohio. At the present time six poison control centers have been established and are in operation throughout the state. These centers have agreed to cooperate in a program to extend their services to any physician requesting information from them. As a matter of convenience the location, address, and telephone number of each of these Ohio centers is noted in the box on facing page. It is suggested that this information be placed near the office telephone and home telephone of every physician.

Activities of OSMA Committee

At the request of the OSMA House of Delegates, the Committee on Poison Control has been exploring the feasibility of a "single central poison control center for Ohio."

Until this study is complete and until findings indicate a recommendation either for or against such a project, a primary function of the Committee on Poison Control is to work with the existing poison information centers of the State and to encourage their accessibility and promote their efficient utilization.

Also at the request of the House of Delegates, the Committee has under consideration a model legislative proposal drafted by the Committee on Toxicology of the AMA, dealing with the accurate and uniform labeling of hazardous household and industrial chemicals. Conferences with retailing and manufacturing groups, the State Pharmaceutical Association and other interested agencies are being conducted with regard to the possibility of presenting this legislation to the Ohio General Assembly in 1959.

In accordance with the House of Delegates resolution, the Committee has under discussion plans for furthering an educational program on prevention of accidental poisoning.

Many Products on Market

With some 250,000 different commercial products on the market, not to mention the thousands of drug products, it is not possible for anyone to be informed as to the contents of more than a few of them. Even the most extensive toxicology library would index perhaps only a few thousand toxic items. Labels on commercial products often give little or no clue to the chemical composition of the contents and the absence of the word "poison" on the label certainly does not imply that the contents of the particular container can be ingested without harm. Many substances in everyday use are not commonly recognized to be toxic if ingested, yet each year a number of deaths occur from such everyday products as furniture polish and cleaning compounds.

Most physicians have at times been in a position of deciding on proper management of a

Poison Information Centers in Ohio Currently in Operation

Location	Facility	Telephone
Akron	Children's Hospital W. Bowery and W. Bechtel	BL 3-5531, Ext. 246
Cincinnati	Kettering Laboratory University of Cincinnati Eden Avenue	PA 1-2345
Columbus	Children's Hospital 561 S. 17th St.	CL 8-9783
Cleveland	Cleveland Academy of Medicine 2121 Adelbert Road	CE 1-4455
Springfield	City Hospital E. High St. and Burnett Rd.	FA 3-5531, Ext. 226
Toledo	Toledo Health Department 635 N. Erie St.	CH 4-1961—(Day) GR 9-2244—(Night)

Clip this box and post near telephone

potentially poisoned individual, usually a child, who has taken a quantity of an agent whose toxic properties are uncertain. A telephone call to a druggist or even to the manufacturer of the product may fail to provide the needed information, or may reveal the substance to be such a complex chemical compound as to further confuse the issue.

The usual recourse to gastric lavage in every such instance may often subject the small child to a most upsetting experience to remove a completely harmless agent from the stomach. Where authoritative information pertaining to a large number of products is made available promptly by telephone to the physician, unnecessary treatment can often be avoided and necessary treatment started without delay.

National Clearinghouse

Poison Information Centers have been proven to be effective in solving some of these problems in about 150 cities in the United States and Possessions. In the past two years the National Clearing House for Poison Information has been established in Washington, D. C., under the Department of Health, Education and Welfare. This center has proceeded to develop a growing file of indexed information compiled on filing cards, each card dealing with an individual agent or product and listing such products by brand names where appropriate.

These files are then printed and distributed to established Poison Information Centers throughout the country where they provide an up-to-date authoritative and relatively complete backbone for the local poison information center. Each month every local center receives an additional set of cards on a growing list of products to be added to its file.

An important feature of the information is the reference to the degree of toxicity of the substance, that is, how much of the product per kilogram of body weight would be expected to produce symptoms or fatality. Each card describes in detail the expected symptoms, time of onset, and the recognized therapy or appropriate antidote. The information on each card is reviewed for accuracy and completeness by three independent, competent authorities before release.

In addition to this card filing system each information center maintains a number of standard references which complete the library of the Poison Information Center.

Staffing The Center

In order for the information center to provide a competent service, it must be staffed by appropriately trained individuals who can obtain and transmit information to the attending physician by telephone day or night. To service the center, most communities have turned to the house staff of a hospital or to the Public Health Service. In this way a resident physician is available to answer any phone request for information from the Poison Library. In most instances he will function simply as an agent to search the available information and pass it along and will not convey his own opinions. He does not therefore act as a consultant nor does he accept any responsibility for the case in point. He is required to make a written report of every call answered and a resumé of the information given and this will become a permanent record filed in the center.

So far only poison information has been mentioned. Most poison information centers operate in conjunction with a treatment facility such as a hospital emergency room. The information center, however, remains independent of the treatment facility and one information center may serve a large area with many facilities for carrying out appropriate treatment. This is what is anticipated in expanding the accessibility of the functioning centers to the whole state. The currently existing centers will expand their information service so that outlying communities will not necessarily be required to establish separate centers.

When The Center Is Called

If a physician has occasion to call upon a center with reference to a potential poisoning he will need to have certain basic facts in mind. These should include at least the following:

1. The full name or brand name of the product ingested or inhaled or, in the case of plant poisoning, the common and generic name if available.
2. An accurate estimation of the amount of the particular agent ingested or if this cannot be ascertained the maximum amount that could possibly have been ingested.
3. The time of ingestion.
4. The age and weight of the patient.

It is not to be implied that the poison information center can be depended upon for information about every possible agent that may serve as a poison. Certainly this is the eventual goal but at present only a relatively modest number of compounds have been indexed and filed. Nevertheless it would appear advisable that every physician contact the information center in his area about any poisoning agent the nature of which is uncertain or unfamiliar to him. Failure to do so would be regrettable if the patient were to experience an unfavorable outcome which could have been avoided. Most areas of Ohio are within a fifty cent toll call of a poison information center, according to information presented to the Committee.

The present program for poison control is only a beginning effort. Plans are in progress for augmenting the service with that of a qualified toxicologist for direct consultation. Safer "child proof" packaging and better labeling of common offending agents is being sought. A study of more effective public and professional education regarding poisons is under way. There is no reason that needless death and disability from poisoning should not be reduced in the next few years.

New Members of OSMA

The following are the names of the new members of the Ohio State Medical Association since September 1, 1958. The list shows the county in which they are affiliated, city in which they are practicing or temporary address in cases where physicians are taking postgraduate work.

Franklin County

Donald Phillip Smith, Columbus

Hamilton County

(Cincinnati unless otherwise indicated)

George P. Balz
Roh Clauss
Ambrose H. Clement
Milton H. Clifford
Robert E. Gregory
Harold B. Hines
Henry J. Kenkel
Frank E. Kuller
Glen E. McPheron
Robert G. Nugent
John F. Popken
Joseph E. Russell
George E. Russo
Jack D. Selzer
John E. Williams
Robert C. Kratz, Ft. Thomas, Ky.

Lorain County

Charles C. Brausch, Avon Lake

Lucas County

Edward J. Kurt, Toledo

Montgomery County

Junius E. Cromartie, Jr., Dayton
Joachim H. Wittoesch, Dayton

Ohioans Included in Insurance Grants for Heart Study

The Life Insurance Medical Research Fund has given 81 awards—two of them in Ohio—totalling $1,098,680 in support of heart research during the coming year. The awards in Ohio both go to Western Reserve University School of Medicine. The first is for research by Dr. Robert M. Berne on the synthesis and utilization of fat by the heart, $11,550; the second, for research by Dr. Henry Rudney on the biosynthesis of cholesterol precursors, $29,700 (the largest award given).

Robert W. Bernlohr, Ph. D., Columbus, was awarded a fellowship by the same fund for study with Dr. G. D. Novelli at the Oak Ridge National Laboratory, Oak Ridge, Tenn. His was one of 24 such fellowships awarded.

Ohio Physicians Participate In Bahamas Conference

Physicians who wish to combine a vacation trip with attendance at a medical conference will be interested in the Bahamas Medical Conference to be held in Nassau, Bahamas, November 28 - December 18.

Three Cleveland physicians are participating on the program. They are Dr. Henry A. Zimmerman, director, Cardiovascular Center, St. Vincent Charity Hospital; Dr. E. Perry McCullagh, Department of Endorcrinology and Metabolism, Cleveland Clinic, and Dr. Charles H. Brown, Section on Gastrointestinal Diseases, Division of Medicine, Cleveland Clinic.

Workmen's Compensation . . .

A Report on How Much Was Expended Through the State Agency for Medical Services to Ohio Workers; Breakdown Shows Other Expenditures

THE Ohio Bureau of Workmen's Compensation during the calendar year 1957 paid out $7,827,104.24 for medical services to injured Ohio workers, according to information provided by the Actuarial Section of the Bureau. That amount excluded a small sum for dental services.

Other 1957 expenditures, exclusive of compensation payments, included the following: $9,749,720.37 for hospital care and nursing; $214,444.22 for funeral expenses, and $61,179.26 for miscellaneous costs. With disbursements for medical expenses added, the total is $17,842,448.09.

These amounts include payments covering treatment of injured private and public employees as well as similar costs for occupational disease claims.

Comparative figures for 1956 were as follows: $8,117,236.42 for medical services; $9,641,846.76 for hospital care and nursing; $246,935.16 for funeral expenses, and $81,742.43 for miscellaneous costs; a total of $18,087,760.77.

The number of claims filed during 1957 was 329,894 or 3.8 per cent less than in 1956.

"Medical-only" claims filed involving payments for physicians' services, but with no compensation for the claimant for loss of time, numbered 263,400 for 1957, or 80 per cent of all claims filed. The average amount paid out for "medical-only" claims increased from $17.80 in 1956 to $22.72 in 1957.

Table 1 is a financial statement of the Ohio Insurance Fund.

Table 2 gives the 1957 awards that have been made to active claims according to the year of injury and having injury dates which in some cases reach back to the beginning of the fund in 1912.

TABLE 1

OHIO STATE INSURANCE FUND

(Workmen's Compensation)

STATEMENT OF FINANCIAL CONDITION

As of December 31, 1957

ASSETS

	Private	Public	P.W.R.E.	Safety & Hygiene	Total
Cash	$ 1,697,130.44	$ 83,726.31	$ 6,148.37	$ 21,338.45	$ 1,808,343.57
Bonds	269,233,368.15	13,285,821.87	969,370.77	3,399,564.21	286,888,125.00
Premiums in Course of Collection	43,703,560.48	6,866,604.19	16,183.69	———	50,586,348.36
Accrued Interest	668,705.18	32,989.94	2,422.59	8,407.80	712,525.51
Administrative Cost Assessment	613,589.80	4,145.30	———	———	617,735.10
Total Assets	$315,916,354.05	$20,273,287.61	$994,125.42	$3,429,310.46	$340,613,077.54

LIABILITIES

	Private	Public	P.W.R.E.	Safety & Hygiene	Total
Reserve for Compensation and Medical	$256,939,373.74	$20,258,247.20	$137,756.00	———	$277,335,376.94
Advance Premium Deposits	41,480,966.80	———	———	———	41,480,966.80
Administrative Cost Assessment	———	1,538.01	———	———	1,538.01
Fund	———	———	———	$3,429,310.46	3,429,310.46
Reserve for Contingencies and Surplus	17,496,013.51	13,502.40	856,369.42	———	18,365,885.33
Total Liabilities	$315,916,354.05	$20,273,287.61	$994,125.42	$3,429,310.46	$340,613,077.54

TABLE 2 — PRIVATE FUND

Medical, Hospital, etc., Awards Distributed to Year of Injury Occurrence
(Accident and Occupational Disease Combined)

Year of Accident or Disease	Awarded	1957 Per Cent	1956 Per Cent
1957	$ 6,698,990	37	41
1956	4,931,667	28	29
1955	1,416,835	8	7
1954	798,965	4	5
1953	555,490	3	4
1952	402,907	2	3
1951	684,151	4	2
1950	359,620	2	2
1949	302,736	2	1
1948	255,934	1	1
1912-1947	1,568,598	9	5
Total	$17,975,893	100	100

Compoc

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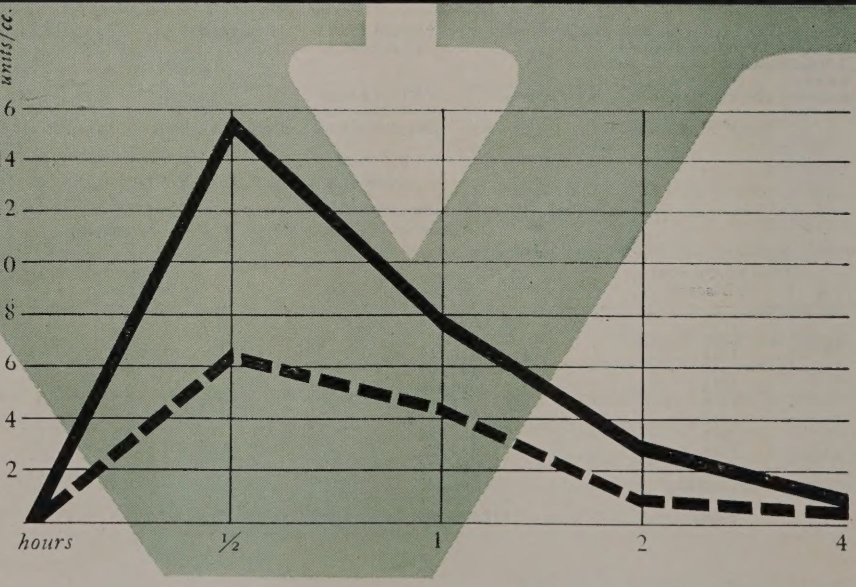

▬ The highest levels of Filmtab Compocillin-VK.

■■ The median levels of Filmtab Compocillin-VK.

Note the high upper levels and averages at ½ hour, and at 1 hour.

Doses of 400,000 units were administered before mealtime to 40 subjects involved in this study.

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blood levels of
potassium
penicillin V

illin®-VK

potassium penicillin V

IN FILMTABS,
Compocillin-VK comes in 125 mg. (200,000 units), bottles of 50 and 100, and in 250 mg. (400,000 units), bottles of 25 and 100.

FOR ORAL SOLUTION,
Compocillin-VK comes in dry granules for easy reconstitution with water. Cherry flavored, the granules are in 40-cc. and 80-cc. bottles. Each 5-cc. teaspoonful represents 125 mg. (200,000 units) of potassium penicillin V.

IN FILMTAB®/ IN ORAL SOLUTION

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AMA Clinical Meeting . . .

December 2-5 Program in Minneapolis Will Feature Programs of Interest In Everyday Practice; Timely Exhibits, Trans-Atlantic Conference, etc.

OHIO doctors will join more than 3,000 physicians expected to attend the American Medical Association's 12th clinical meeting December 2 - 5 in Minneapolis.

Designed to help the family physician solve his daily practice problems, the meeting has been planned in cooperation with Minneapolis physicians. General chairman of the meeting is Dr. O. L. Norman Nelson, Minneapolis, president of the Hennepin County Medical Society. Dr. N. L. Gault, Jr., Minneapolis, is the scientific program chairman.

This is the fifth time the AMA has met in the Twin Cities, although it is the first clinical session. Annual meetings were held in Minneapolis in 1913 and 1928 and in St. Paul in 1882 and 1901.

The scientific portion of the program will be held in Minneapolis Auditorium, while the House of Delegates will meet at the Leamington Hotel, headquarters for the meeting.

Scientific Exhibits

In Minneapolis Auditorium will be 100 scientific exhibits prepared by physicians and the AMA Council on Scientific Assembly. Among them will be exhibits on medical history in Minnesota, including information about Indian medicine and the Mayo Clinic.

There will also be approximately 130 technical exhibits presented by pharmaceutical houses, medical equipment manufacturers, food processors, medical book publishers and other commercial organizations.

Approximately 200 physicians will participate in lecture meetings, symposiums, and panel discussions on such subjects as neurology and psychiatry, cardiovascular disease, arthritis, orthopedics and various other medical topics.

Approximately 35 medical motion pictures will be shown in Minneapolis Auditorium. A special feature will be a symposium on proctology Wednesday evening, December 3. Moderated by Dr. Raymond Jackman, Mayo Clinic, it will include three films made by Dr. Jackman; Dr. Malcolm Hill, Los Angeles, and Dr. Lawrence Abel, London, England.

Trans-Atlantic Conference

Another special feature of the meeting will be a trans-Atlantic conference between AMA members in Minneapolis and British Medical Association members in Southampton, England. It is scheduled for Friday, December 5. The British association will be holding a clinical session at that time.

Closed circuit colored television again will be shown to doctors attending the meeting. It will be sponsored by Smith, Kline and French Laboratories, Philadelphia pharmaceutical house. Programs originating in the Mayo Memorial Building of the University of Minnesota Hospital will be shown in Minneapolis Auditorium. Among the topics will be cardiac by-pass, neurology, orthopedic problems of the extremities, and cesarian section.

The General Practitioner of the Year will be named Tuesday morning at the opening session of the House of Delegates. Dr. Cecil W. Clark, Cameron, La., was the last recipient of the award, given annually to an outstanding American doctor for his medical and civic contributions to his community.

The House of Delegates, members and their wives will hold a banquet Wednesday evening.

The Woman's Auxiliary to the AMA which will hold no regular meetings, will sponsor a series of tours for physicians' wives during the meeting.

Grant Helps Equip Cincinnati University Building

The purchase of $13,748 worth of health research equipment for the new medical research building of the University of Cincinnati College of Medicine has been made possible by the receipt of a grant for that amount from the National Institutes of Health, Department of Health, Education and Welfare, Dr. Stanley E. Dorst, dean of the college, announced.

The grant enabled the UC medical college to finish equipping the $1.7 million annex now under construction. Adjoining the main college building on Eden Ave., the four-story structure will be completed about February 1.

Each year, the company's statisticians report, about 6,000 children from 5 to 14 years of age are killed accidentally. This is two fifths of all the deaths in this age range.—*Metropolitan Life.*

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Reduce fever

Alleviate the general malaise of upper respiratory infections

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Formulas for dependable relief...

...from moderate to severe pain complicated by tension, anxiety and restlessness.

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Codeine Phosphate	gr. ½
Phenobarbital	gr. ¼
Acetophenetidin	gr. 2½
Aspirin (Acetylsalicylic Acid)	gr. 3½

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..from pain of muscle and joint origin, simple headache, neuralgia, and the symptoms of the common cold.

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Acetophenetidin	gr. 2½
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Caffeine	gr. ½

..from mild pain complicated by tension and restlessness.

'EMPIRAL'®

Phenobarbital	gr. ¼
Acetophenetidin	gr. 2½
Aspirin (Acetylsalicylic Acid)	gr. 3½

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BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York

Laboratory Services . . .

Report of Committee Based on Survey of 238 Laboratories Throughout State; Recommendations Are Offered on Ways To Improve Work Done

AT a meeting of the Committee on Public Relations and Economics in the Fall of 1957, there were hearings and discussions on the needs for and methods of improving the quality of clinical laboratory work available to the physicians of Ohio, a subject covered in a resolution adopted by the House of Delegates at the 1957 Annual Meeting.

A subcommittee headed by Dr. H. B. Davidson, Columbus, a member of the main committee, was selected to prepare and present recommendations. The subcommittee members in addition to Dr. Davidson were: Edward L. Burns, M.D., Toledo; Mel A. Davis, M.D., Columbus; Edward A. Gall, M.D., Cincinnati; John B. Hazard, M.D., Cleveland; Ralph J. Johansmann, M.D., Columbus; Melvin Oosting, M.D., Dayton; Robert J. Ritterhoff, M.D., Cincinnati; William Sinclair, Jr., M. D., Cleveland; William B. Smith, M.D., Zanesville; Philip B. Wasserman, M. D., Cincinnati, Arthur E. Rappoport, Youngstown.

When the subcommittee found itself in need of certain basic information it sent a questionnaire to medical laboratories in the state. Reports were received from 238 laboratories.

After consideration of the tabulated survey findings, the subcommittee drew up a set of recommendations for a course of action which seemed advisable at present. These recommendations were approved by the Committee on Public Relations and Economics and subsequently ratified by The Council. The recommendations are as follows:

1. Supervision:

1. Clinical laboratory work is part of the practice of medicine and should be under the supervision of a physician.

2. A physician with special training in laboratory work is a pathologist and therefore clinical laboratory work should be under the supervision of a pathologist.

3. A full time M.D. pathologist is desirable if available; a part time M.D. pathologist is desirable if a full time one is not available; an M.D. supervisor with an M.D. pathologist consultant is desirable if no more extensive arrangement can be made.

4. Encourage hospitals to make some arrangement for M.D. supervision and at least M.D. pathologist consultant service for their laboratories, and help them find a pathologist.

2. Technicians:

1. The best technician training is that outlined by the Registry of Medical Technologists of the American Society of Clinical Pathologists, and such technicians should be utilized wherever possible, or available.

2. If they are not available the technician should have a degree in biologic science.

3. Where non ASCP technicians are necessary, they should be under the supervision of an ASCP trained technician.

4. In order to increase the available number of ASCP trained technicians and to keep good faith with them, all possible aid and help should be given toward their recruitment and toward the betterment of their working conditions including salary.

3. Education:

1. Sponsor programs for directors of laboratories at the time and place of the Annual Ohio State Medical Association Meeting and with programs aimed at new methods and their significance, practical help and advice on existing methods and aids to and methods of insuring accuracy in laboratory work.

2. Sponsor technician training and refresher courses with programs containing the same topics covered in (1) above, given in various regions of the state and given under the auspices of the Ohio State Medical Association.

3. The establishment of a consultation service made up of competent members of the Ohio State Medical Association who are willing to offer their services including time and advice to the laboratories of the state which feel the need of help.

4. To prepare and distribute periodic informational bulletins with practical information on methods and accuracy.

4. Evaluation:

1. This evaluation to be a self evaluation with the aid of standards, controls and unknowns supplied through or by the sponsoring committee from sources such as the College of American Pathologists and the Ohio Department of Health.

5. Development:

1. Encourage and aid in the development of reference or referral laboratories in strategic areas of the state to carry out the more difficult or

less frequently performed types of tests which are not ordinarily available in smaller laboratories and to thereby obviate the necessity of small hospital laboratories referring this type of work to lay laboratories.

2. To develop laboratory services of a type and quality which appear to be needed to meet current trends and developments before this need is exploited by some outside group or before the absence of such services is criticized by some outside group.

6. Activation:

These various endeavors and activities to be carried out by a committee on Laboratory Medicine to be established as a committee of the Ohio State Medical Association, and similar to the present Committee on Maternal Health, Committee on Cancer, Committee on Mental Hygiene and Committee on Rural Health.

The essence of the plan is to provide leadership and offer help to hospital and physician operated laboratories of the state in the provision of proper medical supervision, and properly trained technicians, the maintenance of satisfactory standards of accuracy and in making available a reasonably complete variety of procedures. This is to be done by a permanent committee of the Ohio State Medical Association made up of interested and qualified members.

Cincinnati Academy Adopts Code On Industrial Medicine

The Academy of Medicine of Cincinnati has adopted a code intended to clearly define the scope, objectives, and functions of occupational health programs in Hamilton County. It is in accordance with the general principles of the American Medical Association as published in their booklet "Scope, Objectives and Functions of Occupational Health Programs."

The code states in a positive fashion the place of occupational health programs in the practice of medicine and charts the pathway of communication between physicians in occupational health programs and physicians in the private practice of medicine. The Academy of Medicine of Cincinnati has promulgated this code to establish a better understanding between physicians in the private practice of medicine and those in industrial medicine. Text of the code follows:

Definitions: Occupational health programs are programs provided by management to deal constructively with the health requirements of employees and employers in relation to employment. Industrial Medicine is that branch of medicine practiced by physicians in meeting medical problems and needs under occupational health programs.

Objectives: (1) To promote improvement of health of employees through preventive medicine techniques, such as health education and periodic health examinations.

(2) To examine prospective employees in such a manner as to assure placement on a job which will not be harmful to the employee. To repeat physical examinations when warranted for job reassignment.

(3) To protect employees against extraordinary health hazards in their work environment through periodic examinations.

(4) To immunize employees with tetanus toxoid and immunizations required and incidental to overseas employment; all other immunizations are to be administered by the employee's personal physician.

(5) To transfer all nonoccupational conditions to the care of the personal physician of the employee's choice.

(6) To provide emergency medical service to prevent loss of life and relief of suffering until the employee is placed under the care of a physician of his choice.

(7) To accept the responsibility and direction of treatment of an employee suffering from an occupational disease or injury and, when indicated, refer the employee to a qualified physician for indicated care.

(8) To co-operate with community health services.

(9) To encourage reciprocal relationships with personal physicians that lead to the best health interest of employees, such as,

(a) Encourage employees to have personal physicians.

(b) Upon consent of employee, provide mutual exchange of medical records.

(c) To encourage the personal physician to observe and evaluate the working environment of the employee.

A grant of $22,700 by the National Science Foundation, Washington, D. C., to the University of Cincinnati is for a study to determine the possibility of controlling snails which transmit human blood flukes. Dr. Frank J. Etges, assistant professor of zoology at the University, will be principal investigator.

Motor vehicle accidents far outrank all other types of fatal accidents among women under 65 years of age, and most of these women killed are passengers or drivers rather than pedestrians.—*Metropolitan Life.*

In Memoriam . . .

William W. Baker, M. D., Steubenville, Meharry Medical College, 1920; aged 64; died September 29; member of the Ohio State Medical Association and the American Medical Association. Dr. Baker had been a practicing physician in Steubenville for the past 36 years. He was a member of the Elks Lodge, the Masonic Lodge and the Baptist Church. Surviving are his widow and a son.

Everett T. Bonar, M. D., La Jolla, Calif.; Ohio State University College of Medicine, 1920; aged 65; died September 28; member of the Ohio State Medical Association and the American Medical Association. A native of Rockport, W. Va., and early resident of Woodsfield, Dr. Bonar began his practice in Springfield where he was surgeon for the International Harvester Company. He moved to Columbus in the early 1920's and remained in practice there until about five years ago when he retired. He had been living in California for about two years. He was a member of the Masonic Lodge, the Order of the Eastern Star and the Community Church. Surviving are his widow, a daughter, a granddaughter, a sister and two brothers, one of whom is Dr. Elwood D. Bonar, of Columbus.

George H. Bonnell, M. D., Worthington; Starling Medical College, Columbus, 1906; aged 77; died September 12; member of the Ohio State Medical Association and the American Medical Association. Honored with the 50-Year Award of the OSMA, Dr. Bonnell had been a practicing physician in Worthington for many years. He was a member of the local school board for 16 years. Surviving are his widow; a son, Dr. George H. Bonnell, Jr., also of Worthington; two daughters, two stepsons and a brother.

James A. Coleman, M. D., Toledo; Toledo Medical College, 1898; aged 91; died September 20; member of the Ohio State Medical Association and the American Medical Association. A native of Toledo, Dr. Coleman practiced for virtually a lifetime there and was honored with the 50-Year Award of the OSMA. He was a member of the Catholic Church and the Knights of Columbus.

John J. Coletta, M. D., Columbus, Hahnemann Medical College and Hospital of Philadelphia, 1934; aged 50; died September 22. Dr. Coletta practiced his profession for 24 years in Columbus. He was a member of the Catholic Church. Surviving are his widow, his father, two brothers and three sisters.

John W. Conwell, M. D., Cleveland; Western Reserve University School of Medicine, 1918; aged 67; died September 23; former member of the Ohio State Medical Association and the American Medical Association. Long a practicing physician in Cleveland, Dr. Conwell was active in a number of organizations there. He was a member of the Medical Library Association and formerly played with the Doctors Symphony Orchestra of Cleveland. He was active in Boy Scout work, was a member of the Rotary Club, and several Masonic bodies. Surviving are his widow, a daughter and a son, Dr. John W. Conwell, Jr.

H. Wilbur Cooper, M. D., Lakewood; University of Michigan Medical School, 1900; aged 87; died September 6; former member of the Ohio State Medical Association and recipient of the OSMA 50-Year Award. Dr. Cooper practiced medicine for about 30 years in the Greater Cleveland area, and previously was a resident of Steubenville. His widow survives.

Nora Crotty, M. D., Cincinnati; Cincinnati College of Medicine and Surgery, 1902; aged 89; died September 14; member of the Ohio State Medical Association and the American Medical Association; recipient of the OSMA 50-Year Award. Dr. Crotty practiced for more than a half century in Greater Cincinnati, most of that time in the Clifton area. She was a member of the Catholic Church and the Catholic Ladies of Columbia. Survivors include two sisters and three brothers.

Eugene E. Elder, M. D., Miami Beach, Florida; University of Budapest, Hungary, 1922; aged 68; died October 3; member of the Ohio State Medical Association, the American Medical Association and the American Psychiatric Association. Dr. Elder retired only recently after 13 years as superintendent of the Woodside Receiving Hospital in Youngstown. Prior to that assignment he was at the Massillon State Hospital. He was a member of the Temple, the Zionists and B'nai B'rith. His widow and three brothers survive.

Alfred M. Glazer, M. D., Cincinnati; University of Michigan Medical School, 1929; aged 52; died September 26; member of the Ohio State Medical Association and the American Medical Association; diplomate of the American Board of Internal Medicine. Dr. Glazer began his practice in Cincinnati after completion of his medical training and for 25 years was on the faculty of the University of Cincinnati College of Medicine, in the Department of Internal Medicine. He is survived by his widow, two sons and four brothers.

Harold G. Haines, M. D., Berlin, Penn.; University of Pittsburgh School of Medicine, 1920; aged 63; died September 16 as the result of an explosion and fire in his home. Dr. Haines practiced in Warren from 1920 to 1935, in which year he moved to Pennsylvania. Surviving are a son, his parents and a sister. His wife perished with him in the blaze.

Herman E. Heston, M. D., Ocoee, Tenn.; Starling Medical College, Columbus, 1896; aged 83; died September 19; former member of the Ohio State Medical Association. Dr. Heston practiced in Columbus from 1904 to 1919 and again from 1929 to 1945. A son survives.

Robert A. Keating, M. D., Columbus; Ohio State University College of Medicine, 1937; aged 47; died October 7; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons and specialist in urology. Dr. Keating's entire professional career was served in the Worthington and Columbus area except for time served in the Navy Medical Corps during World War II. He was a member of Phi Rho Sigma. Survivors include his widow, a son, a daughter and his mother.

Delbert V. Kechele, M. D., Bluefield, W. Va.; Western Reserve University School of Medicine, 1920; aged 66; died September 13; member of the American College of Radiology; diplomate of the American Board of Radiology. Dr. Kechele practiced for 22 years in Olmstead Falls before he moved to West Virginia in 1942. Among organizations to which he belonged was the Masonic Lodge. Surviving are two sons, a daughter and a brother, Dr. O. J. Kechele, of Berea.

Sidney N. Mendelsohn, M. D., Cincinnati; University of Louisville School of Medicine, 1929; aged 53; died October 4; member of the Ohio State Medical Association and the American Medical Association; diplomate of the American Board of Surgery. Dr. Mendelsohn practiced his profession in Cincinnati for 28 years. He is survived by his widow, a son, a daughter, two sisters and three brothers, one of whom is Dr. Harry Mendelsohn, of Madisonville in Greater Cincinnati.

James H. Riley, M. D., Norwalk, Conn.; Ohio State University College of Medicine, 1912; aged 69; died September 7; member of the Ohio State Medical Association, the American Medical Association and the American Society of Anesthesiologists. Dr. Riley retired in 1957 after 44 years of practice in Springfield. He was a veteran of World War I, having served with the Army Medical Corps during that war. Survivors include a daughter and a brother.

Earl J. Powers, M. D., Winston Salem, N. C.; University of Cincinnati College of Medicine, 1932; aged 53; died September 28. After completing his medical education in Cincinnati, Dr. Powers practiced for a short time in Washington C. H. before he left the state.

Wiley W. Scott, M. D., Orlando, Fla.; University of Wooster Medical Department, Cleveland, 1909; aged 77; died September 7; member of the Ohio State Medical Association and the American Medical Association; past-president of the Canton Academy of Medicine and former treasurer of the Stark County Medical Society. Dr. Scott practiced medicine in Canton from 1919 to 1946, in which year he retired. Before moving to Canton he practiced in Bolivar. Surviving are his widow, a son and a daughter.

William H. Wilson, M. D., Greenfield; Medical College of Ohio, Cincinnati, 1897; aged 84; died September 7; member of the Ohio State Medical Association and the American Medical Association. A native of the Greenfield area, Dr. Wilson returned there to practice following service in the Spanish-American War. He had been honored with the 50-Year Award of the OSMA. For many years he served on the Highland County Board of Health. Other organizations to which he belonged included several Masonic bodies, the Methodist Church and the Rotary Club. Surviving are his widow, a daughter, a son and a sister.

New Guide To Measure Visual Impairment Published

A set of uniform standards for measuring visual loss and its effect on a person's ability to perform daily activities has been published by the American Medical Association.

For years doctors and laymen have tried to answer the questions: How does a visual deficiency influence a person's ability to live a normal life? How can the degree of impairment of this ability be measured?

The new guide "seeks to provide a simplified method for determining visual impairment and the extent of its effects on an individual's ability to perform the activities of daily living," according to an editorial in the September 27 *AMA Journal,* in which the guide appears.

Licensed Through Endorsement by State Medical Board

The State Medical Board of Ohio has issued licenses to practice medicine and surgery in the State to the following physicians through endorsement of their licenses to practice in other states, or certification by the National Board of Medical Examiners (included are intended residence and medical school of graduation):

June 19, 1958—Vladimirus Bazali, University of Innsbruck, Austria; Martin E. Felder, Columbus, Tufts College Medical School; Roderic O. Jones, Zanesville, Duke University; Walter W. Kolatalo, University of Marburg, Germany; Maurice L. Lewis, Lima, State University of Iowa; Robert F. Lewis, Trotwood, University of Louisville;

Foster Marshall II, Columbus, Medical College of South Carolina; Frederick W. O'Brien, Cleveland Heights, Tufts College Medical School; Zdzislaw J. Rodzinski, University of Cracow, Poland; Morris H. Sable, Cleveland, Chicago Medical School; Thomas C. Sweeney, Cleveland, Northwestern University; Kolbein K. Waering, Nelsonville, Harvard Medical School.

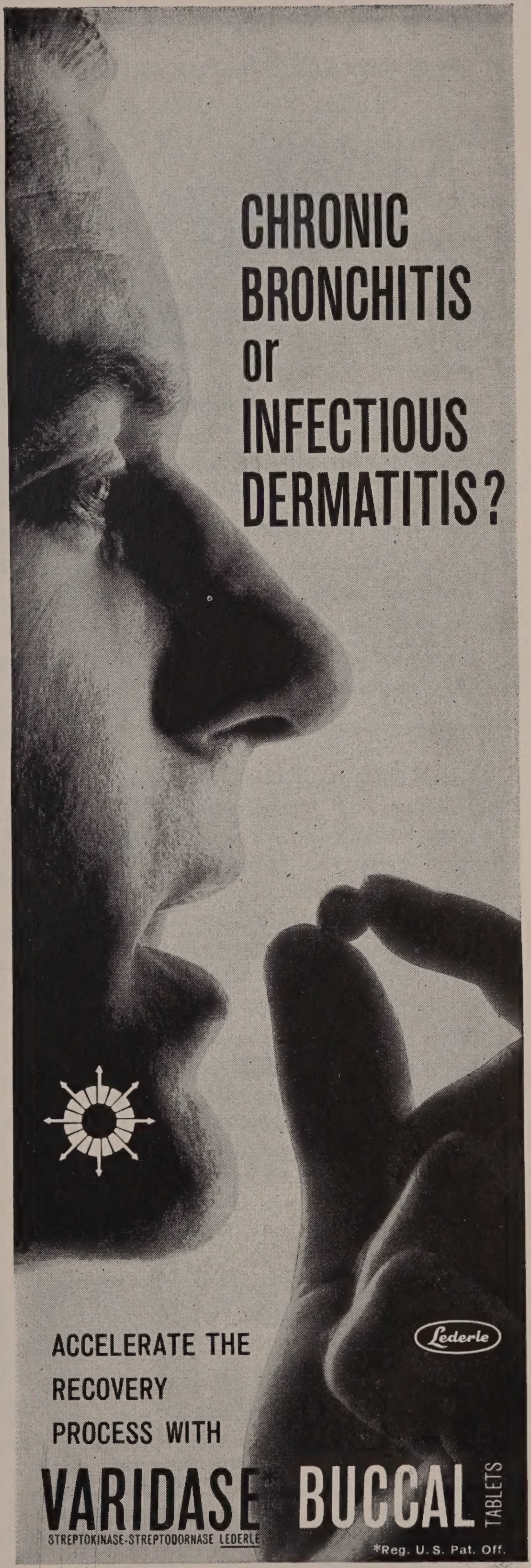
August 19—Marvin R. Agran, Youngstown, Chicago Medical School; Ernest E. Alvin, Jr., Youngstown, Hahnemann Medical College; Elio Baldini, University of Bologna, Italy; Gordon K. Bell, Canton, University of Ottawa; Horst N. Bertram, Dayton, University of Berlin, Germany; Lyle W. Burroughs, Columbus, Washington University; Harvey R. Butt, Jr., Columbus, University of Maryland;

Cahit Corbacioglu, Cleveland, University of Ankara, Turkey; Thomas L. Curtin, Columbus, University of Southern California; David C. Davis, University of Virginia; Alexander P. Demidov, New Lexington, Imperial University of Moscow, Russia; Alice F. Fisher, Cincinnati, University of Rochester; Francis J. Froehlich, Cincinnati, State University of New York;

Herbert W. Goebert, Jr., Warrensville Heights, Hahnemann Medical College; Charles W. Hannah, Sardinia, Indiana University; Herndon P. Harding, Worthington, College of Medical Evangelists; Fleurene P. Holt, Youngstown, Syracuse University; Clyde O. Hurst, Tulane University; Ward S. Jenkins, Toledo, Yale University; Francis E. Kelly, Dayton, New York Medical College;

George M. Leiby, Columbus, Vanderbilt University; Albert M. Lewis, Cleveland, Loyola University; Ping Chung Ling, Marion, University of Arkansas; William D. Loeser, Youngstown, University of Buffalo;

Foster A. McVicker, Bellaire, University of Pittsburgh; John C. Mall, University of Punjab,



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NEW CHANCE FOR MEMBERS TO ENROLL IN GROUP LIFE PLAN OF OSMA FROM NOVEMBER 15 TO DECEMBER 31; WATCH FOR LETTER

MEMBERS of the Ohio State Medical Association and their employees will have another opportunity on November 15 to enroll in the Ohio State Medical Association Group Life Insurance Plan. A letter regarding this is being sent to members by Turner & Shepard, 20 S. Third Street, Columbus 15, administrators of the plan.

Members and employees who did not enroll during the first enrollment period which ended last September 18 will be able to subscribe during the period November 15 to December 31 for the same coverage and at the same rates as during the initial enrollment period.

If 1,000 or more members and their employees subscribe during the November 15 - December 31 period, any one of them may obtain coverage for $10,000 without showing evidence of insurability and an additional $10,000 by showing evidence of insurability.

If less than 1,000 members and employees enroll during the November 15 - December 31 period, only those showing evidence of insurability will be issued a contract.

As of October 20, approximately 2,000 members and their employees have enrolled and been issued contracts.

The rule on new members is that a new member may at any time within 90 days of becoming a member, apply for the OSMA group life coverage without showing evidence of insurability.

India; Alfred F. Michael, Jr., Cincinnati, Temple University; Henry A. Miller, Cleveland, Stanford University; Kenneth L. Miller, Cleveland, Tufts College; Warren N. Morford, Sr., Proctorville, University of Louisville; Thomas F. Moriarty, Jr., Napoleon, University of Louisville; Lyle Moses, Shaker Heights, University of Illinois; Henry L. Murphy, Cincinnati, Meharry Medical College; James A. Murray, Fostoria, Jefferson Medical College;

George Naymick, Medical College of Virginia; Ellen Newman, Cleveland, Columbia University; James M. Orth, Akron, Northwestern University; Edward P. Passaro, Jr., Columbus, University of Rochester; Richard B. Peoples, Toledo, Jefferson Medical College; George B. Prozan, Cleveland, New York State University; Kathryn A. Rainbow, Oberlin, Meharry Medical College; Howard T. Robinson, Warren, Johns Hopkins University; Paul E. Roth, Northwestern University; David T. Rowlands, Jr., Cincinnati, University of Pennsylvania;

Ralph C. Schwarz, Cincinnati, St. Louis University; Howard C. Smith, Painesville, University of Buffalo; Charles E. Ward, Delaware, Medical College of Virginia; Jack C. Wilhoit, Cincinnati, University of Louisville; Charles B. Wilkinson, Cincinnati, Howard University; Raymond V. Wizbowski, Toledo, University of Michigan.

Symposium on Medical Technology Is Offered in Cleveland

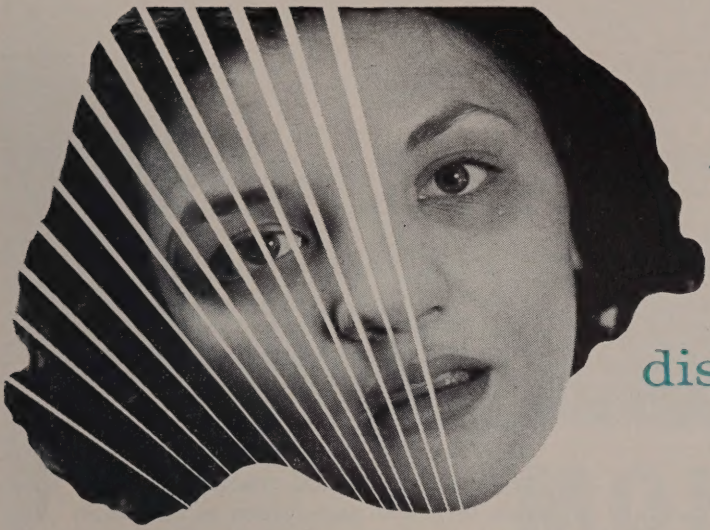
The Frank E. Bunts Educational Institute (affiliated with The Cleveland Clinic Foundation) and The Cleveland Society of Medical Technologists offer a symposium on Medical Technology November 20 and 21. Applications are limited to 125 and will be honored in order received.

At the Symposium special attention will be given to the practical aspects of current and newly developed techniques. The program will be of interest to medical technologists and clinical laboratory supervisors.

On the day previous to the opening of the Symposium, there will be a limited number (absolute limit 20) of places available at a Parasitology Workshop directed by the Communicable Disease Center of Chamblee, Georgia.

The Cleveland Clinic is located at Euclid Avenue and East 93rd Street, and may be contacted for details.

With the continuing rise in the educational level, by 1975 more than one half of the adult population will have at least a high-school education, and almost one tenth will have received a college degree. Among the white male population, about one seventh will have completed college.—*Metropolitan Life.*



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*A Symposium on the Pharmacologic Effects of Dartal on the Liver, Chicago, Searle Research Laboratories, Feb. 7, 1958.

Activities of County Societies . . .

First District

(COUNCILOR: CHARLES W. HOYT, M. D., CINCINNATI)

ALLEN

Dr. F. Mason Sones, of the Cleveland Clinic, was guest speaker for the September 16 meeting of the Allen County Academy of Medicine at the Shawnee Country Club in Lima. The subject of his talk was "Cine Fluorographic Studies in Cardiac Disease."

Second District

(COUNCILOR: R. DEAN DOOLEY, M. D., DAYTON)

CLARK

The Clark County Medical Society September 15 gave its endorsement to a proposal to build a new school for retarded children in Clark County.

The endorsement came in a society vote at the general meeting held in Hotel Shawnee, Springfield.

Voters here November 4 will decide if the county will get a new school for the children. The proposal on the ballot is for one-tenth of a mill for 10 years.

Sixty-eight persons, including 14 interns from Mercy and City Hospitals, attended the dinner meeting and heard Dr. Samuel Saslaw, professor of medicine at Ohio State University College of Medicine, talk about "Present Day Antibiotic Therapy."

Dr. Edwin A. Roberts, Dr. David D. Smith and Dr. Lincoln L. Moore were voted associate members for one year.—Tom Duross, Executive Secretary.

MIAMI

Dr. Thomas G. Skillman, assistant professor in the Department of Internal Medicine, Ohio State University, discussed the recent work with oral hypoglycemic agents to members of the Miami County Medical Society on September 12 at Dettmer Hospital.

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

PORTAGE

The regular meeting of the Portage County Medical Society was held September 16, at Robinson Memorial Hospital, Ravenna. After a business meeting, Mr. Sidney Mountcastle, executive secretary of the Summit County Medical Society, presented an outline of the program for the Sixth Councilor District Postgraduate Day in October. A film from the National Society for the Prevention of Blindness, on "Glaucoma" was presented, pointing out the advantages of screening for glaucoma by the general practitioner.

Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

MAHONING

Following is an excerpt from a report in the *Youngstown Vindicator:*

Dr. George F. Lull, assistant to the president of the American Medical Association, urged physicians to greater participation in community problems before 200 members and wives of the Mahoning County Medical Society Saturday evening, Sept. 27.

At the Past Presidents Commemoration Banquet at the Hotel Pick-Ohio Ballroom, Dr. Lull said that "one of the chief afflictions among professional and business men in our complex society today seems to be a lack of interest in what the other fellow is doing."

Following his speech, Dr. Lull presented testimonial scrolls to 27 physicians who have held the office of president of the Mahoning County Medical Society. Dr. Andrew A. Detesco, president of the Society, introduced each past president.

Dr. Lull was introduced by Dr. C. A. Gustafson, councilor for the Sixth District of the Ohio State Medical Association and a past president of the Mahoning County Medical Society.

SUMMIT

The Summit County Medical Society had as guest speaker on October 7 Colonel Andres I. Karstens, deputy commander, Aero-Medical Laboratories, Wright-Patterson Air Force Base. Colonel Andres discussed tolerance to high altitude and space flying as well as the hazards and feasibility of space flight.

For the fourth successive year, the Summit County Medical Society is sponsoring a series of public forums, in cooperation with the University of Akron and the *Akron Beacon Journal.*

Discussions center around medical problems in three broad classifications. Topics for discussion are: "Problems of the Aged," "The Crippled, Deformed or Deficient Child," and "The Teen-Ager's Physical and Mental Problems."

TRUMBULL

At the October meeting of the Trumbull County Medical Society, Dr. Cyrus Maxwell, a[illegible] director of the Washington Office of the AMA, was the speaker of the evening. Dr. Maxwell dis-

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cussed problems that arise in Washington regarding legislation relating to medical and health matters.

Consideration of the affiliation of a portion of the Trumbull County Tuberculosis Hospital with Trumbull Memorial Hospital for use in handling patients with chronic diseases was sent back to committee for further study after the matter was presented before the Society at the last meeting.

Seventh District

(COUNCILOR: ROBERT HOPKINS, M. D., COSHOCTON)

COLUMBIANA

Dr. Donald Effler, of the Department of Thoracic Surgery, Cleveland Clinic, was guest speaker at the dinner meeting of the Columbiana County Medical Society on September 23. His discussion was on the subject of "Open Heart Surgery."

TUSCARAWAS

Members of the Tuscarawas County Medical Society and the Tuscarawas County Bar Association with their wives held a joint meeting at the Union Country Club. Speaker for the occasion was Attorney Sherlock H. Evans, Massillon humorist, who spoke on "Pink Pills for Pale People." The get-together is planned as an annual event.

Ninth District

(COUNCILOR: C. L. PITCHER, M. D., PORTSMOUTH)

HOCKING

The following is an excerpt of a report in the *Logan News:*

The Hocking County Medical Society voted its "unanimous approval of the progressive public health program developed during the past five years since passage of the public health levies."

The medical society also endorsed proposed renewal of levies for the health department and tuberculosis care, which will be voted on in November.

This was one of several matters taken up by the medical society.

The Hocking society appointed a committee to prepare a fee schedule, which later will be submitted for approval of the medical society, county commissioners and the county welfare department.

Members of the committee are Dr. J. Ward Doering, chairman; Dr. Owen F. Yaw and Dr. Petras Balsevicius.

The society also voted to endorse and approve the Logan city school board's action in requiring all pupils entering the first grade to be vaccinated against polio.

It was further recommended that the county school board urge all local boards to establish the same requirement for each of its respective schools.

Policy on Salk polio vaccine was set forth as follows: members of the medical society will vaccinate all of their own patients and will furnish vaccine for the health department to give to all pre-school children whose parents feel they cannot afford to pay for it, also to all pregnant women of all ages.

The medical society also endorsed "fluoridation of all drinking water systems in Hocking County, where feasible."

The physicians accepted an invitation for a joint dinner meeting with the Hocking County Bar Association, for a discussion of medical jurisprudence.

SCIOTO

Dr. William Havener, acting chairman of the Department of Ophthalmology, Ohio State University, Columbus, spoke on the subject, "Red Eye, Differential Diagnosis and Treatment," for the September 8 meeting of the Scioto County Medical Society in Portsmouth. A buffet supper was held following the 9:00 o'clock meeting in the Nurses Recreation Hall of General Hospital.

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

FRANKLIN

The following report is from the *Columbus Dispatch:*

Columbus Academy of Medicine announced it will sponsor a free health clinic for the citizens of Franklin County, March 18-22 in the Veterans Memorial.

Dr. Robert M. Inglis, academy president, said the exhibit, first of its kind, will be presented to provide the public a better insight on matters of health.

Each of the approximately 40 displays will be manned by a physician who will explain the exhibit and answer questions.

The exhibits will feature a series of scientific displays relating to newer concepts in the field of medicine and allied health professions. The academy will present authoritative and factual information in easily understood terminology.

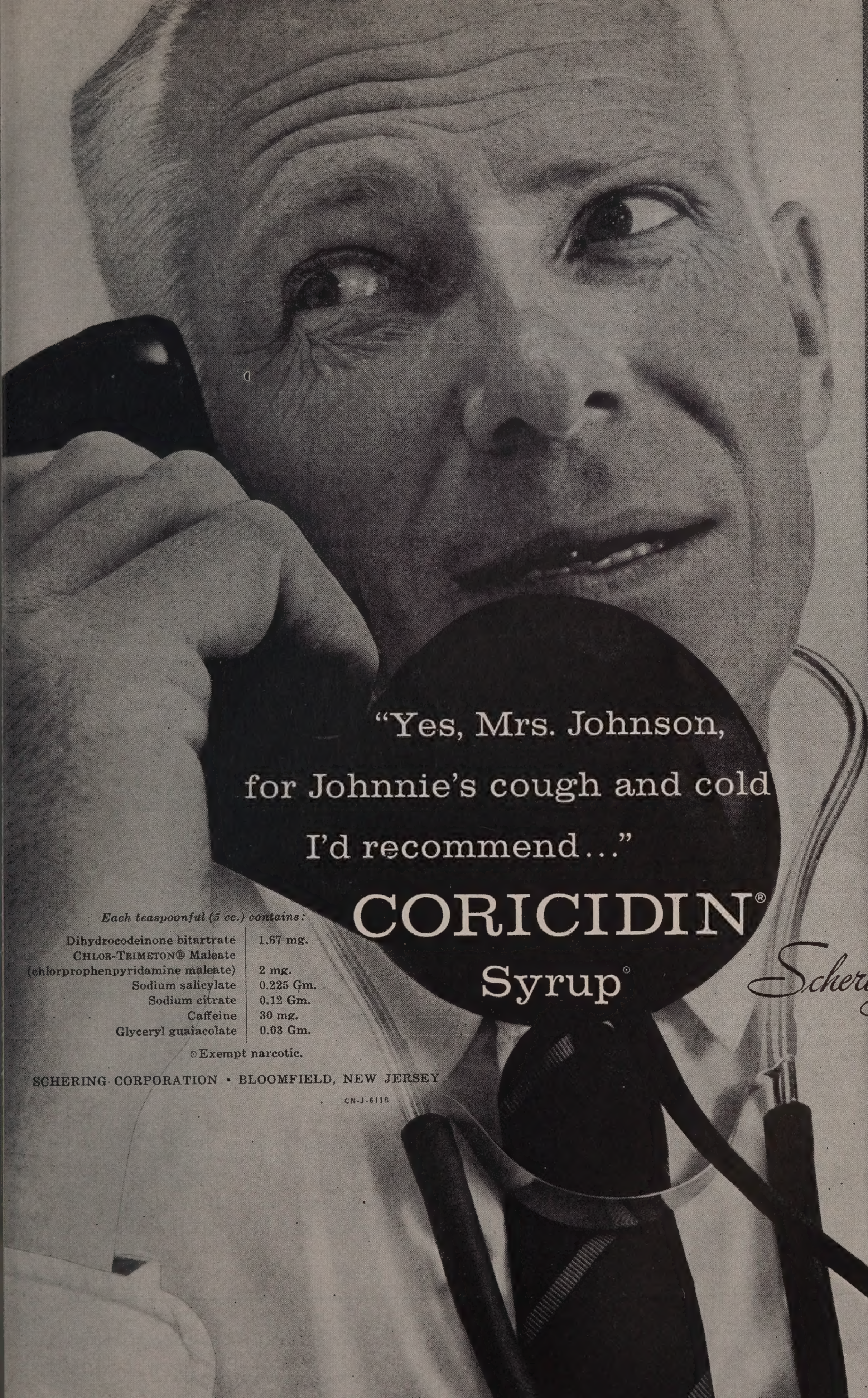
Guided tours will be conducted for school children, the academy announced.

Eleventh District

(COUNCILOR: H. T. PEASE, M. D., WADSWORTH)

ERIE

His experiences regarding motor vehicle accidents were discussed by Dr. Samuel Gerber,



"Yes, Mrs. Johnson, for Johnnie's cough and cold I'd recommend..."

CORICIDIN® Syrup⊙

Schering

Each teaspoonful (5 cc.) contains:

Dihydrocodeinone bitartrate	1.67 mg.
CHLOR-TRIMETON® Maleate (chlorprophenpyridamine maleate)	2 mg.
Sodium salicylate	0.225 Gm.
Sodium citrate	0.12 Gm.
Caffeine	30 mg.
Glyceryl guaiacolate	0.03 Gm.

⊙Exempt narcotic.

SCHERING CORPORATION • BLOOMFIELD, NEW JERSEY

CN-J-6118

Cuyahoga County coroner, at the October 15 meeting of the Erie County Medical Society in Sandusky. Dr. Gerber also offered suggestions as to how fatalities may be lessened.

RICHLAND

The September meeting of the Richland County Medical Society was held at the Sky Club, with the doctors' wives as guests.

Other guests attending included Dr. H. T. Pease, Councilor of District No. 11, and Dr. M. D. Prugh, chairman of the State Organization of the American Medical Education Foundation.

After a very enjoyable dinner, a business meeting was held during which Doctor Prugh presented the official Award of Merit of the AMEF to Doctor Curtiss, President of the local Society, in recognition of the Society's special contributions to the AMEF.

After the business meeting, Dr. W. E. Wygant introduced the speaker of the evening, Mr. L. C. Mitchell, professor of art at Ohio University, Athens, Ohio, who presented a fascinating demonstration of water color drawing with a running accompaniment of dry humor, which was greatly enjoyed by all present.—John J. Clark, M. D., Secretary.

New Directory of U. S. and Canada Physicians Published by AMA

The United States and Canada have a population of more than 250,000 physicians.

These physicians are all listed in the new 20th edition of the American Medical Directory, published by the American Medical Association.

The Directory lists 250,621 physicians as compared to 240,638 in the 1956 edition.

Published as a service to physicians and the public, the directory lists for each physician his age, address, date of licensure, specialty, and membership in specialty medical groups.

The U. S. has 90,359 general practitioners in private practice and 77,655 specialists. There are 7,320 doctors in medical schools, research, and other work outside of private practice, and 17,303 holding full-time jobs on hospital staffs.

Other figures about the new directory are 18,398 new names; 1,214 names of physicians whose addresses are unknown, and 7,870 names have been deleted because of death.

Doctors are participating in the shifting national population, directory statistics show. Although New York still leads in the number of doctors—30,986—it also leads—with 360—those

(Continued on Page 1506)

Annual Clinical Conference

CHICAGO MEDICAL SOCIETY

MARCH 2, 3, 4, and 5, 1959

Palmer House, Chicago

Daily Half-Hour Lectures by Outstanding Teachers and Speakers on subjects of interest to both general practitioner and specialist

Panels on Timely Topics

Teaching Demonstrations

Medical Color Telecasts

Scientific Exhibits worthy of real study and helpful and time-saving Technical Exhibits

The Chicago Medical Society Annual Clinical Conference should be a MUST on the calendar of every physician. Plan now to attend and make your reservation at the Palmer House.

new Tao*

PRONOUNCED TAY-O

(brand of triacetyloleandomycin with gluCOSAmine)

Capsules / Oral Suspension

designed for effective control of common gram-positive infections

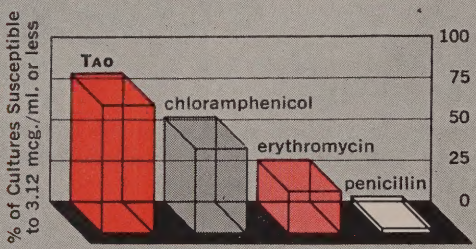
effective . . .

CLINICAL RESULTS	adults	children	all Staph infections
Cured	172 (80%)	148 (89%)	71 (88%)
Improved	28 (13%)	8 (5%)	7 (9%)
Failure	17 (7%)	11 (6%)	3 (3%)

Types of infecting organisms: The majority of identified etiologic microorganisms were Staph. aureus and Staph. albus. Tao has its greatest usefulness against organisms such as: staphylococci (including strains resistant to other antibiotics), streptococci (beta-hemolytic strains, alpha-hemolytic strains and enterococci), pneumococci, gonococci, Hemophilus influenzae.

even against resistant staph[1,2] . . .

Per cent of "antibiotic-resistant" epidemic staphylococci cultures susceptible to Tao, erythromycin, penicillin and chloramphenicol.[1]



well tolerated . . .

REACTIONS:

(a) adults	(b) children
Total—9.2% (20 out of 217)	Total—0.6% (1 out of 167)
Skin rash—1.4% (3 out of 217)	Skin rash—none
Gastrointestinal— 7.8% (17 out of 217)	Gastrointestinal— 0.6% (1 out of 167)

There was complete freedom from adverse reactions in 94.5% of all patients. Side effects in the other 5.5% were usually mild and seldom required discontinuance of therapy.

plus . . . stability in gastric acid • rapid, high and sustained blood levels • high urinary concentrations • outstanding palatability in a liquid preparation.

Dosage and Administration: Dosage varies according to the severity of the infection. For adults, the average dose is 250 mg. q.i.d.; to 500 mg. q.i.d. in more severe infections. For children 8 months to 8 years of age, a daily dose of approximately 30 mg./Kg. body weight in divided doses has been found effective. Since Tao is therapeutically stable in gastric acid, it may be administered at any time, without regard to meals.

Supplied: Tao Capsules—250 mg. and 125 mg.; bottles of 60. Tao for Oral Suspension—1.5 Gm.; 125 mg. per teaspoonful (5 cc.) when reconstituted; unusually palatable cherry flavor; 2 oz. bottle.

References: 1. English, A. R., and Fink, F. C.: Antibiotics & Chemother. (Aug.) 1958. 2. English, A. R., and McBride, T. J.: Antibiotics & Chemother. (Aug.) 1958. 3. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy (Aug.) 1958. 4. Celmer, W. D., et al.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 476.

ROERIG NEW YORK 17, N. Y.

Division, Chas. Pfizer & Co., Inc. SCIENCE FOR THE WORLD'S WELL-BEING

*TRADEMARK

states showing losses of doctors since the last directory.

States with the biggest gains in physicians include: California, 1,040; Florida, 382; Michigan, 218; Ohio, 113; Arizona, 57; Oregon, 44, and Washington, 31.

Among those in the loss of column are Illinois, 318; Pennsylvania, 220; Minnesota, 159; Missouri, 150, and Iowa, 114.

When the first directory was published in 1906 it contained 128,173 names.

A copy may be obtained from the AMA office in Chicago at a cost of $35.00.

Credentials Deposit Service Is Offered by WMA

The following letter regarding a special service offered to physicians by the World Medical Association was received by the Ohio State Medical Association from Frank W. Barton, secretary, AMA Council on National Defense:

"The World Medical Association has initiated a program which the American Medical Association commends to your attention.

"On July 1, 1958, the services of a Central Repository for Medical Credentials became available to doctors of the world. During war and national uprisings, medical records are often lost or destroyed. Because of this, many doctors are today unable to utilize their professional skills because of the loss or destruction of their original credentials and a lack of a protective service in which authenticated copies could be deposited. Therefore, The World Medical Association has undertaken a program to assure that the doctor will always be able to prove himself medically trained and fully accredited to practice medicine.

"In the United States, the lifetime cost of the service on a one-payment basis to the newly graduated doctor is approximately $60.00. An actuarial schedule has been established for doctors in the various age groups. A 10-year service rate is also available.

"Repository officials suggest that the credentials deposited include official medical school record, medical diploma, and specialist credentials. American doctors should *not* send their original credentials, but should send photostatic, microfilm, or notarized copies of their original credentials.

"Requests for forms and additional information in regard to the Central Repository for Medical Credentials is available from The World Medical Association, 10 Columbus Circle, New York 19, New York."

Malpractice Prophylaxis

Maintaining
Unimpeachable
Records

Specialized Service
makes our doctor safer

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for the convenience of the Physicians and Surgeons—and the many people they serve

Three Prescription Departments

maintained in a high class manner with large staff of registered Pharmacists

Other Complete Departments

OFFICE EQUIPMENT
PHYSIO-THERAPY APPARATUS
HOSPITAL SUPPLIES

W-B Pharmaceutical Supplies

JOBBING STOCKS ALL LEADING MANUFACTURERS

Antitoxins and Vaccines in Special Refrigeration Plants

Prompt Service on Phone Orders

all cold symptoms

New timed-release tablet provides:

...the superior decongestant and antihistaminic action of Triaminic

...non-narcotic cough control as effective as with codeine, but without codeine's drawbacks

...an expectorant to augment demulcent fluids

...the specific antipyretic and analgesic effect of well-tolerated APAP

...the prompt and prolonged activity of timed-release medication

Each* Tussagesic *Tablet contains:

TRIAMINIC®	50 mg.
(phenylpropanolamine HCl	25 mg.;
pheniramine maleate	12.5 mg.;
pyrilamine maleate	12.5 mg.)
Dormethan (brand of dextromethorphan HBr)	30 mg.
Terpin hydrate	180 mg.
APAP (N-acetyl-para-aminophenol)	325 mg.

Tussagesic Tablets provide relief from *all* cold symptoms in minutes, lasting for hours.

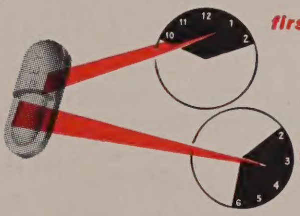
Dosage: One tablet in the morning, mid-afternoon, and in the evening, if needed. The tablet should be swallowed whole to preserve the timed-release action.

To reduce upper respiratory congestion and irritating secretions.

For non-narcotic control of the cough reflex.

To augment demulcent respiratory secretions.

For specific, highly effective antipyresis and analgesia.



first —3 to 4 hours of relief from the outer layer

then —3 to 4 more hours of relief from the inner core

Also available—for those who prefer palatable liquid medication— Tussagesic suspension

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Activities of Woman's Auxiliary . . .

CHAIRMAN PUBLICITY COMMITTEE—Mrs. W. J. Horger, 1100 Ohio Ave., East Liverpool, Ohio
(See Page 1395 for roster of officers.)

CLARK

New members were honored and committee chairmen appointed at the first meeting of the year of the Clark County Auxiliary held in the home of Mrs. G. Robert Horton, Springfield. Fifty members were present.

Mrs. Lincoln Moore, Mrs. John Richsteiner, Mrs. Edwin Roberts, Mrs. Harold Shanklin, and Mrs. David Smith were welcomed as new members.

Mrs. W. H. Crays, president, appointed the following to serve as committee chairmen for the year: Attendance, Mrs. J. N. Hebble; Calling, Mrs. A. K. Howell; Civil Defense, Mrs. George A. Smith; Credits and Awards, Mrs. C. W. Hullinger; Finance, Mrs. W. J. Habeeb; Historian, Mrs. A. T. Anton; Hospitality, Mrs. D. H. Guyton; Legislation, Mrs. E. L. Ringer, Membership, Mrs. N. B. Pavlotos; Mental Health, Mrs. Max Graves, Mrs. Samuel Leber, co-chairman; AMEF, Mrs. J. F. Riesser; Nurse Recruitment, Mrs. J. A. Davidson; Parliamentarian, Mrs. E. P. Greenawalt; Philanthropy, Mrs. Charles E. Fralick; Program, Mrs. R. A. McLemore; Publicity, Mrs. Frank Anzinger, Jr.; Public Relations, Mrs. George P. Fitzgerald, Jr.; Scholarship, Mrs. E. W. Schilke; Safety and Rehabilitation, Mrs. G. F. Parker; *Today's Health,* Mrs. C. J. Townsend; Ways and Means, Mrs. H. E. Sanders, Mrs. R. B. Beam, co-chairman; Yearbook, Mrs. James Gianakopoulas; T. V., radio, and visual education, Mrs. J. W. Elliott.

Yearbooks prepared by Mrs. James Gianakopoulas were distributed. Mrs. Crays reported that Clark County had won first in the state among counties of its size for its sale of *Today's Health* and had won second place in the national contest for which the local Auxiliary received a cash prize of $25.

Mrs. Robert Beam, Mrs. Fralick and Mrs. Fitzgerald, Jr., were in charge of the tea which was served following the meeting. Mrs. Robert Arthur and Mrs. E. P. Greenawalt was the welcoming committee. Mrs. E. C. Nehls and Mrs. C. D. McIntire presided at the tea and coffee urns.

COLUMBIANA

The Woman's Auxiliary to the Columbiana County Medical Society held the first fall meeting, a luncheon, September 16, at the home of Mrs. Charles Gerace of East Liverpool.

Three State Officers were present, Mrs. Margaret Bauman, 6th District Director, of Warren, Mrs. Frances Thomas of Gorrettsville second vice-president, and Mrs. William J. Horger of E. Liverpool state publicity chairman.

Mrs. Bauman and Mrs. Thomas were presented money corsages. These were worn for a while and then the money was donated to the AMEF fund.

Mrs. William Banfield, president, presided.

Mrs. Charles Gerace gave out the year books and spoke briefly of the year's program. She then gave the theme for the year "Safe Guard To-Day's Health for To-Morrow."

Mrs. James Locke spoke on "Exploring the World of Gems."

Mrs. William Banfield and Mrs. William Horger were co-hostess.

CUYAHOGA

The Woman's Auxiliary to the Academy of Medicine of Cleveland has completed plans for its number one project—The American Medical Education Foundation.

A Christmas card designed by a doctor's son, Frank E. Bunts, is the means of the money making campaign. It is a discreet holiday card bearing the words, "Seasons Greetings," complete with the traditional holly wreath and the caduceus—the symbol of peace and healing.

Mrs. William A. Nosik is chairman of this project.

The Interstate Post Graduate Medical Association of North America, will have its annual meeting in Cleveland again this year. The Auxiliary members will man the Hospitality room at the Statler Hotel for three days, and be hostesses at a tea, luncheon and fashion show. Mrs. M. M. Perlich is hospitality chairman, and Mrs. T. T. Zuck co-chairman.

The Auxiliary will be represented by its president Mrs. F. Rittinger and others at the Public Health Committee meeting of the Cleveland Woman's City Club, and at the Community Chest and Red Cross meetings.

HAMILTON

The October meeting of the Woman's Auxiliary to the Academy of Medicine of Cincinnati was held Tuesday, October 21, at the Country Club. Following luncheon, the business meeting was presided over by Mrs. Earl C. Van Horn, president.

Dr. Esther Marting spoke on "Russian Medicine: Is It a Woman's World?"

Chairmen of the Day were Mrs. C. Wilke, pro-

if you were
in the rheumatoid arthritic's shoes,
Doctor...

wouldn't you want a steroid
with a proved record
of safety and success?

METICORTEN®

prednisone

you can count on rapid relief from pain, swelling and stiffness followed by functional improvement and maintained on an uncomplicated, low-dosage regimen **with minimal chance of side effects**† **and without unexplained weight loss, anorexia, muscle cramps** as reported with certain other corticoids†

†Round-table Discussion by Leading Investigators, San Francisco, Calif., June 20, 1958.

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METICORTEN, 1, 2.5 and 5 mg. white tablets.

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gram chairman, and Mrs. E. H. Schweitzer, hospitality chairman.

KNOX

Activities for the fall and winter of the Woman's Auxiliary to the Knox County Medical Society were started with the meeting September 24 in the home of the president, Mrs. George Imhoff.

Mrs. C. E. Cassaday and Mrs. O. W. Rapp represented the Auxiliary at the Fall Conference September 8 in Columbus. Mrs. Julius Shamansky reported on the state meeting of the Golden Age club in Columbus September 22.

The secretary read a letter from the county nurses acknowledging the audiometer given for use in the county schools. They have screened 1,192 pupils to date.

The members voted a donation of $50 toward a folding machine for Golden Age bulletins and an invitation was received from the Columbus Academy of Medicine to meet with them on October 20.

MEDINA

The Woman's Auxiliary to the Medina County Medical Society entertained the Eleventh District of the Woman's Auxiliary to the Ohio State Medical Association on September 22, at a brunch at the Westfield Country Club. Mrs. John L. Jones of Medina is 11th District director.

Among the guests attending were State officers: Mrs. C. H. Bell of Mansfield, president; Mrs. C. A. Colombi of Cleveland, president-elect and Mrs. J. N. Wychgel of Shaker Heights, director of the 5th District.

A program was presented following the brunch. Included on the agenda was a one-act play on mental health education, entitled "Tomorrow is a Day," presented by the Medina Masquers, making up the Medina Society's part in the program.

Richland County Society presented a skit on Country Fair, which included an exhibition of nursing dolls, with a history of dolls, being given by Mrs. S. Lerro.

Erie County gave a report on their project with the AAPS essay contest and the Huron Society reported on their project in selling *Today's Health Magazine*."

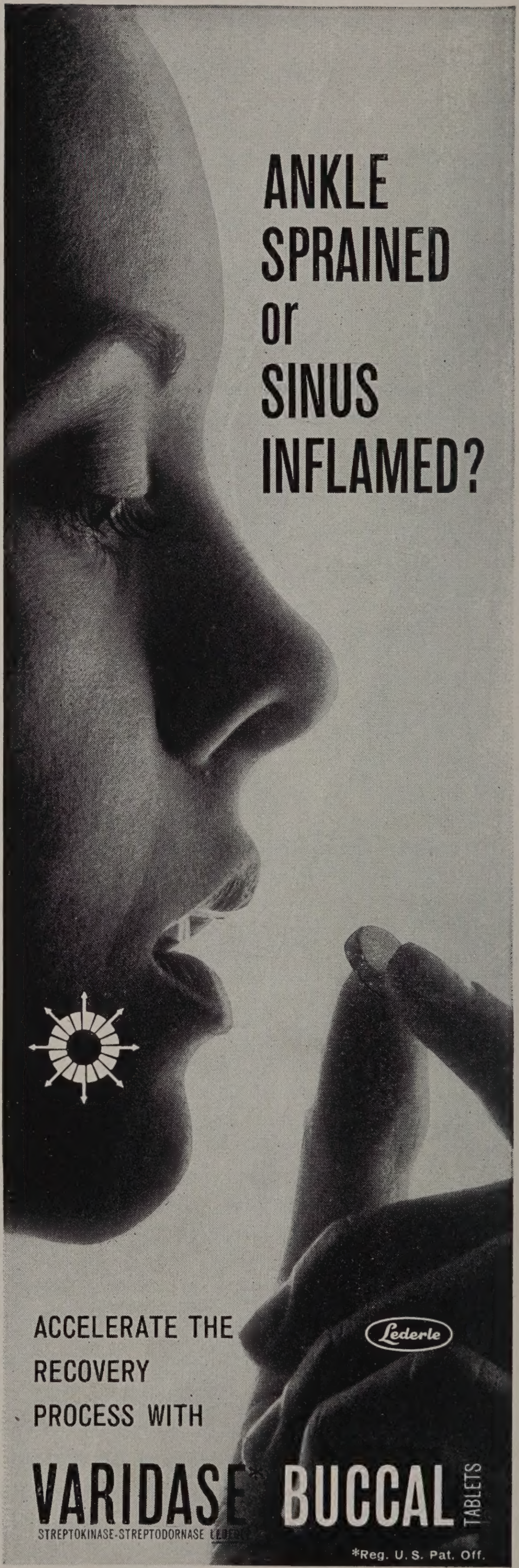
Lorain County members discussed ways and means for raising money for Auxiliary projects.

RICHLAND

The Woman's Auxiliary to the Richland County Medical Society met for luncheon at the Woman's Club on September 3. Thirty-Nine members were present.

In introducing Mrs. C. H. Bell, the State Auxiliary President, Mrs. Wain, local County President, urged all members to attend National and State meetings, if possible.

Mrs. Bell reported on the 35th Annual Wom-



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in delicious chocolate-like nuggets

There's nothing easier to give
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A real treat . . .
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tops with adults, too.

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Vitamin A	5,000 Units*
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Vitamin C	75 mg.
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Vitamin B-1	2.5 mg.
Vitamin B-2	2.5 mg.
Vitamin B-6	1 mg.
Vitamin B-12 Activity	3 mcg.
Panthenol	5 mg.
Nicotinamide	20 mg.
Folic Acid	0.1 mg.
Biotin	30 mcg.
Rutin	12 mg.
Calcium Carbonate	125 mg.
Boron	0.1 mg.
Cobalt	0.1 mg.
Fluorine	0.1 mg.
Iodine	0.2 mg.
Magnesium	3.0 mg.
Manganese	1.0 mg.
Molybdenum	1.0 mg.
Potassium	2.5 mg.

*U.S.P. UNITS †INT. UNITS

Dose: One Nugget per day
Supplied: Boxes of 30–one month's supply
Boxes of 90–three months' supply or family package.

an's Auxiliary to the AMA Convention, held June 22-26 in San Francisco.

Mrs. Bell called attention to the facts that there has been a gain in National membership of over 2000 members; three Ohio women are working on the National Board; Ohio won a top award for *Today's Health* subscriptions plus an award of merit for contributions to AMEF and that the Woman's Auxiliary is now incorporated and known as the National Auxiliary.

In calling for new business, Mrs. Wendell Bell stated that seven members of the Auxiliary had been approached by the Red Cross to assist in finding a chairman and committee heads for the Red Cross.

ROSS

Following a social hour with the Ross County Medical Society, September 6, at the home of Dr. R. L. Counts, the Woman's Auxiliary to the Society met for a business meeting and dessert at the home of Mrs. William Corzine, Jr.

Mrs. Robert Quinn presided and announced Mrs. J. C. Berno will be the new chairman of the magazine, *Today's Health*. She will be assisted by Mrs. Robert Swank. Mrs. R. E. Lightner reported on the nurses loan fund and stated that a loan had been made to a Kingston girl now entering training.

Mrs. Quinn stated that the group had sold 228 per cent of its magazine quota and was now rated as one of the most exclusive clubs. Mrs. Dow Scholl was chairman of the project during that time.

Mrs. William Garrett, mental health chairman, reported on the proposed mental health center to be located in Chillicothe.

Mrs. William Garrett, Mrs. Lourell Smith, Mrs. R. E. Lightner and Mrs. Robert Quinn represented the Auxiliary at the Fall Conference, September 8, in Columbus. Mrs. Walter Kramer, state safety chairman, also attended.

SCIOTO

The Woman's Auxiliary to the Scioto County Medical Society held its first fall meeting at the home of Mrs. William Hugenberg, Portsmouth, September 10.

The guest speaker was Dr. Raymond Carson whose subject was "Mental Health." He told of future plans for a "Guidance Center" in the area and the need of more volunteer service at the local Receiving hospital. The group was then entertained by Dr. Carson as a humorist and ventriloquist.

During the business meeting reports were given by eight members who recently attended the fourteenth annual conference of the woman's auxiliary to the Ohio State Medical Association at Columbus.

A social hour concluded the afternoon's meeting.

SUMMIT

The Woman's Auxiliary to the Summit County Medical Society held its Sixth annual hat parade and garden party on August 14, at the home of Dr. and Mrs. George T. Conger. This is the only fund raising project, the proceeds going to benefit the Nurses Revolving Loan Fund. This year the society had nine requests for loans. At present eight girls have made use of the funds, five at City Hospital, two at St. Thomas, and one at the University of Akron.

The Hobby Show for oldsters was held September 5, 6, and 8 in O'Neil's auditorium. Applicant must be 65 years of age or older and be able to show some handiwork he has done since his 65th birthday. There were approximately 138 exhibits this year, and it was said that these were the best ever displayed. This has been attributed to the keen competition which has developed among the hobbyists. A green ribbon is awarded to the most unusual exhibit. This year Mr. Clayton Schnabel earned this award with his unusual collection of dried seeds which were so neatly and interestingly displayed. Mrs. Mary Hurt, 90, and Mr. John Barnhart, 92, were again crowned queen and king, this honor going to the oldest hobbyists.

Several new booths were added this year to benefit the oldsters. The YMCA taught social bridge and cribbage. "The Art of Living for Senior Citizens" was directed to oldsters with no skills and therefore no hobbies. There was information, literature, guides, names of people and agencies who might help to direct these senior citizens to a new purpose in life.

As a result of last year's show, a year-round

NEIL TRAINING SCHOOL

DELAWARE, OHIO **Phone 3-2932**

COUNTRY HOME AND SCHOOL

For Mentally Deficient Boys — Ages 3 to 15

Mrs. H. A. Copeland, Director

"neck-itis"

or any rheumatic "itis"

Sigmagen®
tablets
CORTICOID-SALICYLATE COMPOUND

more potent and comprehensive treatment than salicylate alone
...assured anti-inflammatory effect of low-dosage corticosteroid[1]
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more easily manageable corticosteroid dosage
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hobby center for oldsters has been set up in the Akron area. The auxiliary along with the United Community Council was instrumental in the organization of the Senior Citizens of Summit County, Inc. The oldsters had a building donated to them which they have named Krumroy Union No. 1. The building is a year-round center for socializing, practicing of crafts, classes, sales outlet, etc. Their membership has grown to approximately 200. On September 13, the oldsters held their first open house. The auxiliary furnished refreshments for this event.

The annual membership tea was held September 18, at the home of Dr. and Mrs. Arthur Dobkin. Approximately 30 new members attended and were welcomed at this time. Mrs. Edwin A. Riemendschmeider and her co-chairman Mrs. Anastasius H. Kyriakides were in charge of the arrangements and were assisted in the decorations by Mrs. Aris W. Franklin. Past-presidents presided at the tea table.

On October 7, the Woman's Auxiliary to the Summit County Medical Society met at the Smorgasbord in Stow. Betty Jaycox, woman's editor of the *Akron Beacon Journal,* spoke on "Personalities in the News." Following the program, President Mrs. Devitt L. Gordon presided at the business meeting.

TRUMBULL

Members of the Auxiliary to the Trumbull County Medical Society met with their husbands for dinner at the Squaw Creek Country Club on September 17. Congressman David Dennison addressed the combined group. Following the program, which had been arranged by the doctors, the Auxiliary held its regular business meeting.

The meeting was conducted by the president, Mrs. John Grima. Mrs. George Mokris called the members attention to the series of radio programs being sponsored by the Medical Auxiliary over the local station WHHH. They will be heard at 6:30 P. M. on the last Friday of each month. The first one was September 26, entitled "Over 35."

The Medical Auxiliary endorses two "Grey Ladies" activities for its members. They will continue to serve as nurses' aides at the Crippled Children's Clinic, and they will help two days out of each month at the Red Cross Blood Bank.

The Medical Society asked the Public Relations Committee of the Auxiliary to sponsor in the High School of Trumbull County, the essay contest promoted by the Association of American Physicians and Surgeons. The essays bear the title "The Advantages of Private Medical Care" or "The Advantages of the American Free Enterprise System."

Cook County
Graduate School of Medicine

INTENSIVE POSTGRADUATE COURSES

STARTING DATES — WINTER 1958-1959

SURGERY—Surgical Technic, two weeks, Dec. 1, Feb. 2. Surgery of the Colon & Rectum, one week, Dec. 1, Mar. 2. Fractures & Traumatic Surgery, two weeks, Dec. 1. Treatment of Varicose Veins, two days, Dec. 15. American Board Review Course, two weeks, Apr. 6. Blood Vessel Surgery, one week, Mar. 2.

GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, two weeks, Feb. 9. Vaginal Approach to Pelvic Surgery, one week, Nov. 17, Feb. 2. General & Surgical Obstetrics, two weeks, Feb. 23.

MEDICINE — Electrocardiography, two-week basic course, Mar. 16. Gastroscopy & Gastroenterology, two weeks, Mar. 2. Board Review Course, one week, Apr. 20.

DERMATOLOGY—Clinical & Didactic Course, two weeks, Nov. 3.

UROLOGY—Ten-Day Practical Course in Cystoscopy, by appointment.

RADIOLOGY—Diagnostic X-Ray, two weeks, Dec. 1.

TEACHING FACULTY — ATTENDING
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THE LATEST "TIMED DISINTEGRATION" CAPSULE

- BALANCED APPETITE DEPRESSANT
- CENTRAL NERVOUS STIMULANT
- NUTRITIONAL SUPPLEMENT

Each Standex capsule contains:

D'Amphetamine Sulfate	7.5 mg.
Amobarbital	30.0 mg.
Vitamin B-1	1.0 mg.
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Calcium Pantothenate	1.0 mg.
Niacinamide	20.0 mg.
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there's pain
and inflammation here...
it could be mild or
severe, acute or chronic,
primary or secondary fibrositis
or even early
rheumatoid arthritis

...in any case
it calls for

Sigmagen
corticoid-salicylate compound Tablets

more potent and comprehensive treatment than salicylate alone

... assured anti-inflammatory effect of low-dosage corticosteroid[1]
... additive antirheumatic action of corticosteroid plus salicylate[2-5] brings rapid pain relief; aids restoration of function

more easily manageable corticosteroid dosage

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METICORTEN® (prednisone)	0.75 mg.
Acetylsalicylic acid	325 mg.
Aluminum hydroxide	75 mg.
Ascorbic acid	20 mg.

Packaging: SIGMAGEN® Tablets, bottles of 100 and 1000.

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Complete information on the use of SIGMAGEN available on request.

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5 G-J-198

Cleveland Office of the VA Announces Series of Clinical Conferences

The Cleveland Regional Office of the Veterans Administration has announced a series of clinical conferences which began in October and will continue through January 1959. The conference room is on the 7th floor of the Cuyahoga Building. Clinical conferences, with Dr. Charles Berns, as chairman, are scheduled on Wednesdays from 8:00 to 9:00 a. m. The following dates, subjects and speakers have been announced:

November 5—"Interesting Medical Cases"—Dr. S. Kessler.

November 12—"Some Ocular Manifestations of Systemic Diseases"—Dr. Nicholas J. Johnson.

November 19—"Social Service in Cleveland Regional Office"—Mr. F. P. Straub.

December 3—"Clinical Pathological Conference" —Dr. F. Bayless.

December 10 — "Facial Plastics" — Dr. J. G. Himmel.

December 17—"Recent Advances in Heart Disease"—Dr. J. B. Tuckerman.

January 7, 1959—"Cancer of the Cervix"—Dr. R. E. Bowman.

January 14—"Rating Board Medical Problems"—Rating Board Doctors.

January 21—"Carcinoma of Prostate—Diagnosis and Treatment"—Dr. Harry Trattner.

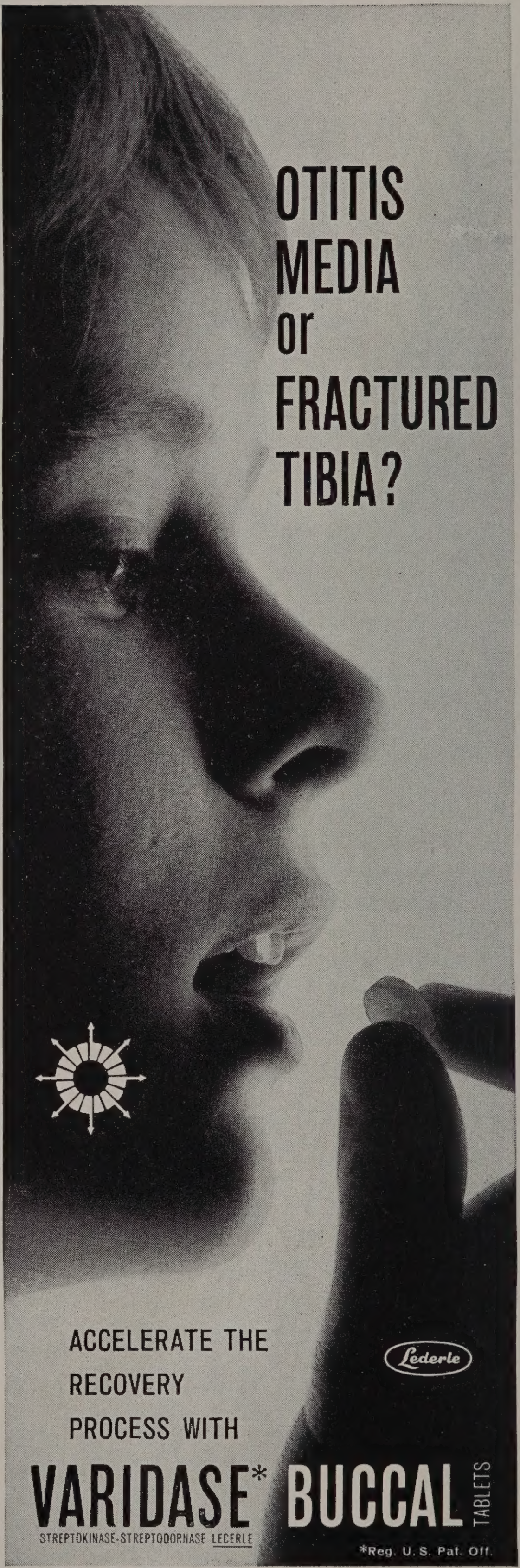
January 28—"VA Research on Psychotherapy and Tranquilizers"—Dr. H. S. Curtis and Dr. M. S. Slobin.

Ft. Steuben Academy

"Consideration of Some Diffuse Pulmonary Fibroses," was the topic discussed at the October 14 meeting of the Fort Steuben Academy of Medecine in Steubenville. Speakers were Dr. Elliot Lasser, professor of radiology at the University of Pittsburgh, and Dr. David Greenberg, radiologist at the Ohio Valley Hospital, Steubenville.

The number of orphans has dropped from 6.4 million in 1920 to 2.7 million in 1958, says Health Information Foundation. Yet the child population has risen from 39 to 60 million in that time.

A typical child born today has 25 chances in 1,000 of losing his mother by death before he reaches 18 and 57 chances in 1,000 of losing his father. Fewer than one out of every thousand children in the country nowadays has lost both parents.—*Health Information Foundation.*



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Three Organizations List Films Available

Three developments in the medical motion picture field are of interest to Ohio physicians. First is the announcement that "MD International," a color film on work of American doctors abroad produced by Smith, Kline and French Laboratories in cooperation with the AMA, is available on a loan basis. Physicians may obtain the film on loan without charge by writing to Smith, Kline and French Medical Film Center, 1500 Spring Garden Street, Philadelphia 1, Pa.

Second, "Reach for Tomorrow," a documentary film of five human experiences along the road to rehabilitation narrated by Henry Fonda, may be rented for $3.50 plus postage from the National Society for Crippled Children and Adults, Inc., 11 South LaSalle Street, Chicago 3, Illinois.

Third, the Ohio Division of Mental Hygiene, State Office Building, Columbus, has published a list of sound films available for adult use only. The list contains films for general adult viewing, parents, teachers, and physicians and other professional persons.

Physicians also will find of interest the film "San Francisco—1958." This 30-minute production features summaries of the AMA's 1958 annual meeting by five of the top physician-speakers on the program.

Life Insurance Fund Promotes Many Heart Research Projects

Over 100 research programs devoted to heart disease were supported during 1958 by the Life Insurance Medical Research Fund, according to the fund's annual report. Over $1,086,000 has been allocated to continue this support. The fund is supported by 144 life insurance companies. Its resources are devoted entirely to heart research. Since the fund's organization in 1945, over $10,300,000 has been contributed to this vital work.

Industrial Nursing

A concentrated course in Industrial Health for registered nurses only is offered for the fifth consecutive year by the Institute of Industrial Health of the University of Cincinnati during the week of March 2nd, 1958. The faculty, under the Directorship of Dr. Robert Kehoe, will include the staff of the Institute and selected guest instructors.

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SUPPLIED: plastic squeeze bottles, ½ oz.

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XYLOCAINE
VISCOUS

Xylocaine Viscous provides quick-acting and prolonged surface anesthesia for sore and painful throats, particularly those occurring after tonsillectomy and adenoidectomy. Its cherry-flavored, water-soluble vehicle spreads evenly and adheres intimately to the membranes. Nonirritating and nonsensitizing. Dose: 1 teaspoonful, swished around in the mouth and then swallowed slowly.

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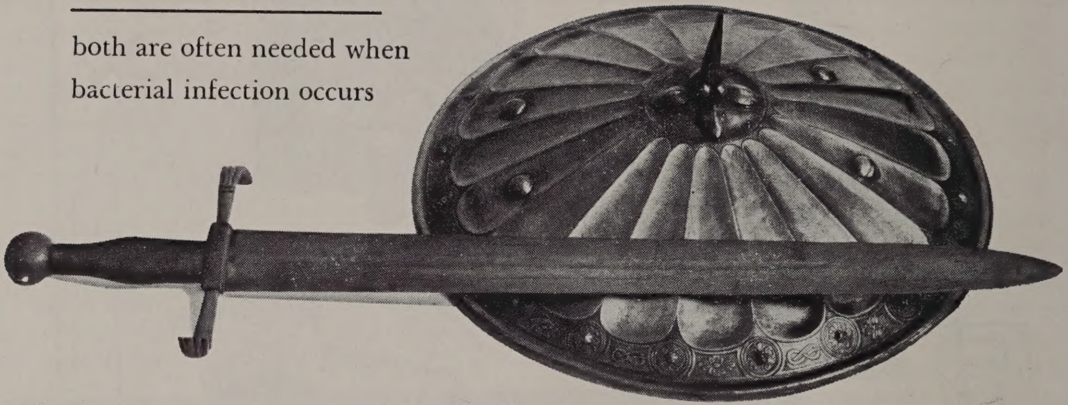
both are often needed when bacterial infection occurs



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Mysteclin-V contains tetracycline phosphate complex

It provides a direct strike at all tetracycline-susceptible organisms (most pathogenic bacteria, certain rickettsias, certain large viruses, and Endamoeba histolytica).

It provides the new chemical form of the world's most widely prescribed broad spectrum antibiotic.

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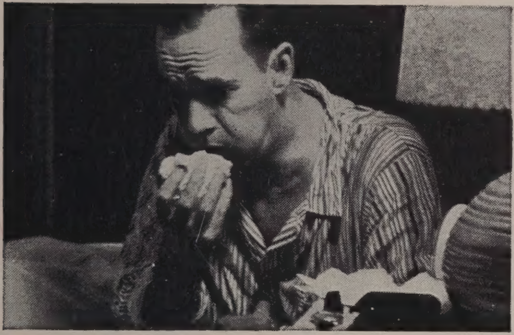
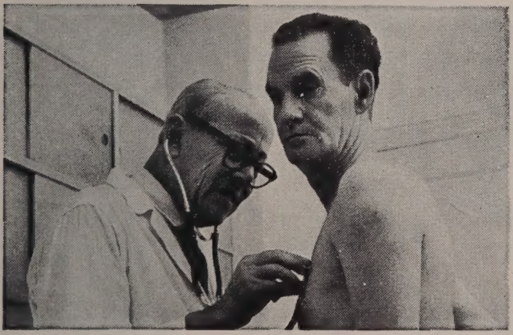
Pyribenzamine® EXPECTORANT breaks up cough

even persistent cough

Patient, factory worker, age 43, had suffered for months with persistent, dry cough, which he termed "smoker's hack."



Cough frequently interrupted his sleep, causing him to be nervous, irritable; his job efficiency was impaired.



Chest X-ray was negative and the plant physician prescribed PYRIBENZAMINE EXPECTORANT with Ephedrine. Patient noticed almost immediate relief– a week later felt "considerably better."

Pyribenzamine Expectorant with Ephedrine provides a unique combination of antitussive agents, which work three ways at once to break up the persistent cough: *Pyribenzamine* relieves histamine-induced congestion throughout the respiratory tract; *ephedrine* relaxes the bronchioles and makes breathing easier; *ammonium chloride* liquefies mucus, relieving dry cough and promoting productive expectoration.

Supplied: Pyribenzamine *Expectorant with Ephedrine*, containing 30 mg. Pyribenzamine citrate (equivalent to 20 mg. Pyribenzamine hydrochloride), 10 mg. ephedrine sulfate and 80 mg. ammonium chloride per 4-ml. teaspoon. Also available: Pyribenzamine *Expectorant with Codeine and Ephedrine*, same formula as above with the addition of 8 mg. codeine phosphate per 4-ml. teaspoon (exempt narcotic).

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...rich in important unsaturated fatty acids, contains 56% linoleic acid

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EASY AND PLEASANT TO ADMINISTER

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EFFECTIVE

Extensive recent clinical findings now show that serum cholesterol levels tend to be lower when an adequate amount of Mazola Corn Oil is part of the daily meals... high levels are lowered... normal levels remain normal.

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Nutrition authorities commonly recommend that from one-third to one-half of the total fat intake should be of the unsaturated type, whenever serum cholesterol control is a problem. The high content of important unsaturated fatty acids in Mazola, plus its other desirable characteristics, make it the oil of choice.

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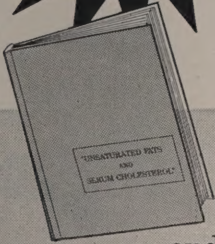
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MEPROLONE suppresses the inflammatory process and simultaneously relieves aching and stiffness caused by muscle spasm, to provide greater therapeutic benefits and a shorter rehabilitation period than any single antirheumatic-antiarthritic agent.

MEPROLONE-2 is indicated in cases of severe involvement, yet often leads to a reduction of steroid dosage because of its muscle-relaxant action. When involvement is only moderately severe or mild, MEPROLONE-1 may be indicated.

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b

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c

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ACHROMYCIN* Tetracycline equivalent to Tetracycline HCl	125 mg.
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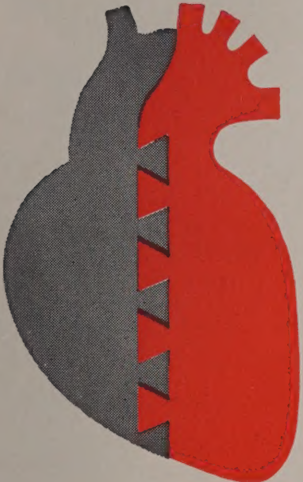

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1. *Friedlander, H. S.: The role of ataraxics in cardiology. Am. J. Card.* **1***:395, March 1958.*
2. *Shapiro, S.: Observations on the use of meprobamate in cardiovascular disorders. Angiology* **8***:504, Dec. 1957.*

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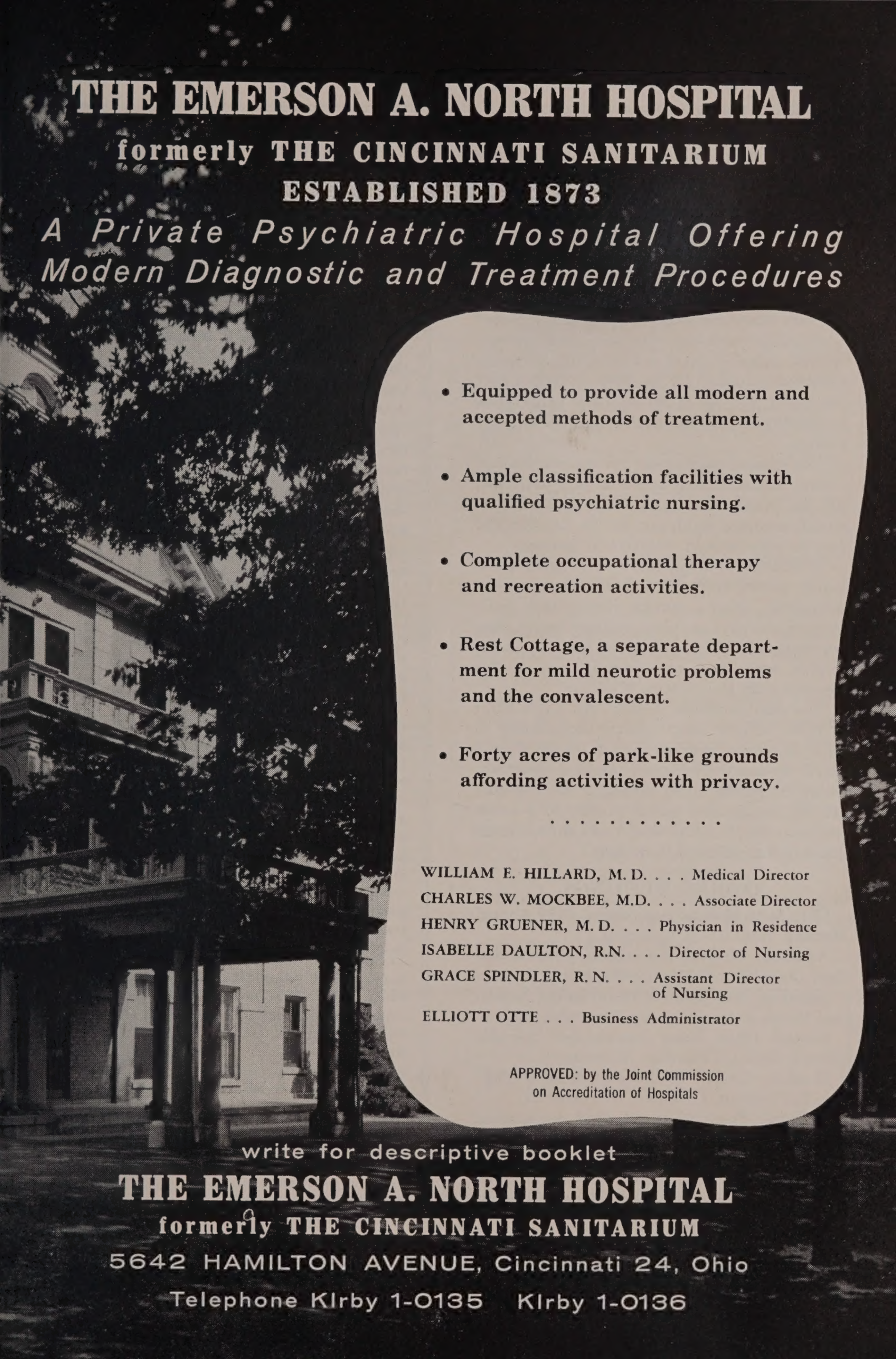

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Steel Union Studies Plans for Hospitals and Clinics

The following special article appeared in the *New York Times* under an Atlantic City dateline on September 19:

"The United Steelworkers of America took the first step toward setting up its own chain of hospitals and medical centers to meet the health needs of its 1,250,000 members.

"The move reflected mounting labor dissatisfaction with Blue Cross and other programs approved by organized medicine. The steel union asserted that its members were not receiving adequate protection in return for the $134,224,000 a year now being paid for health insurance under plans jointly financed by the steel companies and the workers.

"The closing session of the union's biennial convention unanimously approved an investigation into the practicability of establishing facilities to provide complete health care for the members and their families through collective bargaining.

"In addition to hospitals, such a program would include clinics, diagnostic centers, rest homes, rehabilitation centers, nursing homes and "fully pre-paid medical care plans utilizing group practice medicine." The only union that now has a program embracing any substantial part of this objective is the United Mine Workers.

"The steel convention directed that a new effort be made in next year's contract negotiations to force the companies to pay the full cost of life and health insurance and other medical programs. Under the present 50-50 sharing of the insurance bill, the average steel worker pays $9.50 a month for insurance. A shift would add $100,000,000 a year to the industry's labor costs."

COMING MEETINGS

Ohio State Medical Association, 1959 Annual Meeting, April 21-24, Columbus.

American Medical Association, Clinical Session, December 2-5, Minneapolis, Minn.

American Association of Blood Banks, Netherland-Hilton Hotel, Cincinnati, November 20-22.

Central Ohio Heart Association, Scientific Council Session, Columbus, November 5.

Franklin County Academy of General Practice, Fall Seminar, Columbus, November 21.

Interstate Postgraduate Medical Association, 43 International Medical Assembly, Cleveland, November 10-13.

Southwestern Ohio Society of General Physicians, University of Cincinnati, Series of Courses on Radiology, Tuesdays, as announced.

Veterans Administration, Series of Clinical Conferences, Cleveland, Wednesday Evenings.

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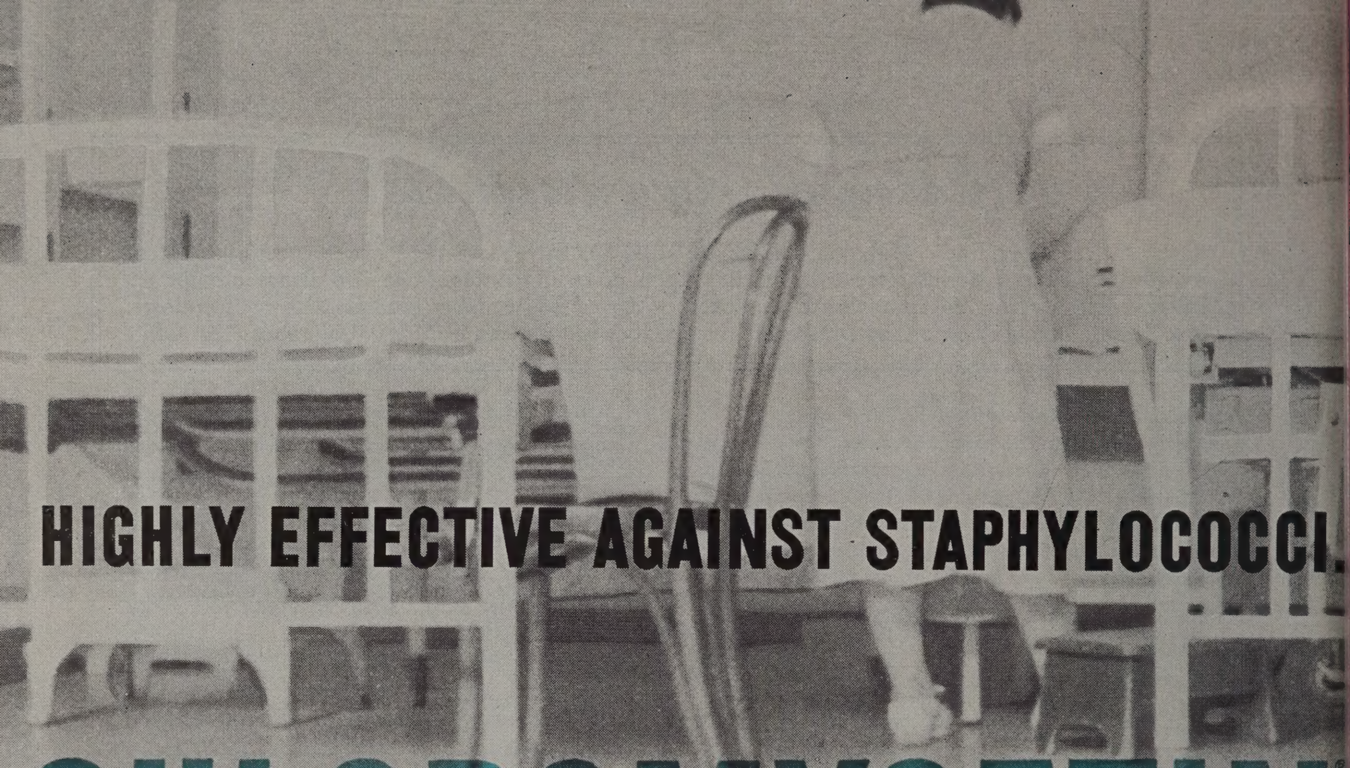

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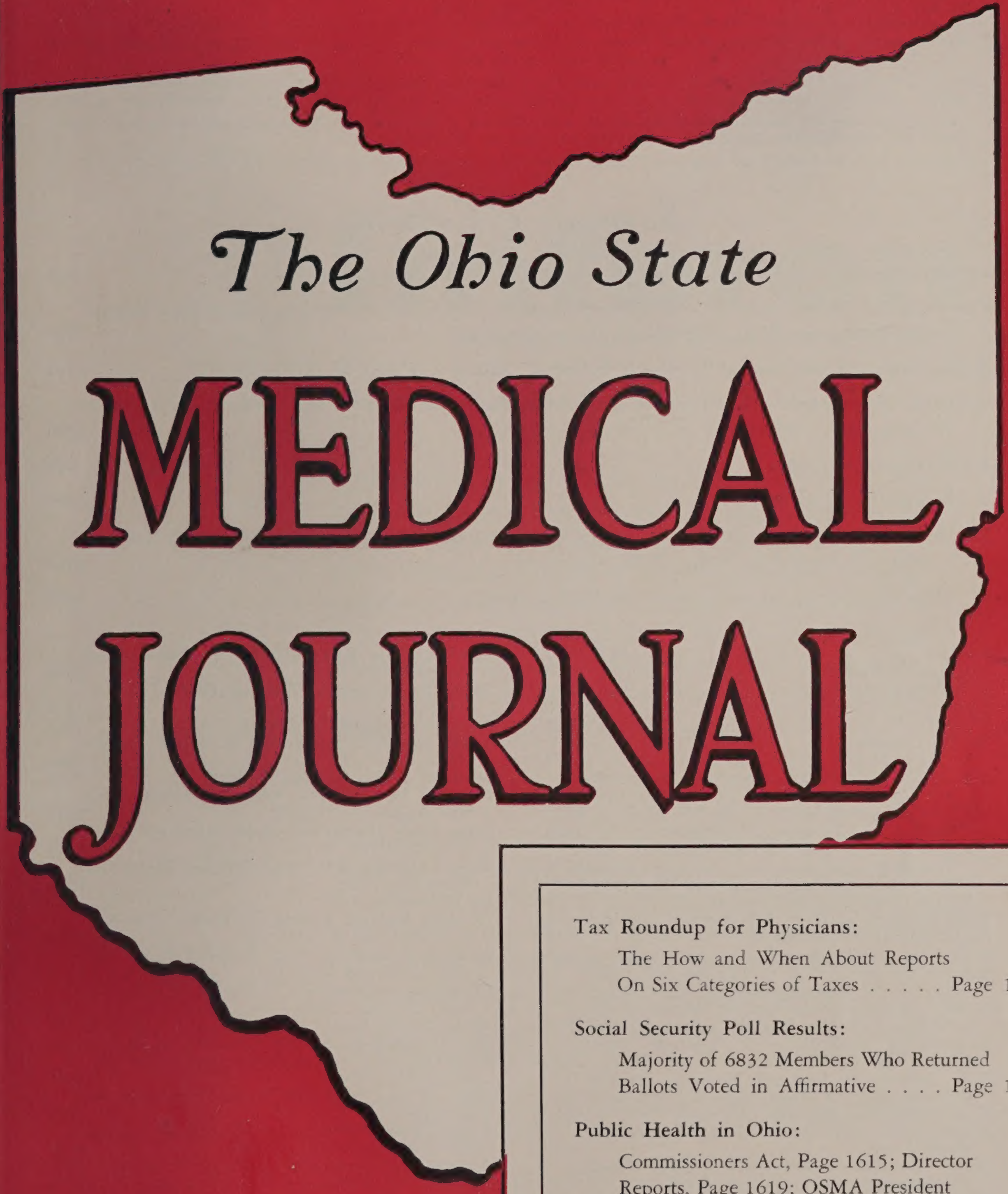

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The Ohio State Medical Journal

Vol. 54 December, 1958 No. 12

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The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

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(1) Hagedorn, A. B.: Proc. Staff Meet. Mayo Clin. 32:705 (Dec. 11) 1957.
(2) Best, W. R.; Louis, J., and Limarzi, L. R.: M. Clin. North America (Jan.) 1958, p. 3.

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(Continued on next page)

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ADAMS—Sam C. Clark, President, Cherry Fork; Hazel L. Sproull, Secretary, West Union. 3rd Wednesday, April, June, August, October, December.

BROWN—Donald L. Domer, President, Georgetown; Vytautas Karoblis, Secretary, Ripley. 1st Sunday, monthly.

BUTLER—John R. Perkins, President, Middletown; Mr. Charles G. Greig, Executive Secretary, 110 North Third Street, Hamilton. Last Wednesday of alternate months.

CLERMONT—Richard D. Carr, President, Williamsburg; Harry M. Breuer, Secretary, New Richmond. Third Wednesday, monthly.

CLINTON—Roy D. Goodwin, President, Wilmington; H. Richard Bath, Secretary, Wilmington. 2nd Tuesday, monthly.

HAMILTON—J. Robert Hudson, President, Cincinnati; Mr. Edward F. Willenborg, Executive Secretary, 152 East Fourth Street, Cincinnati 2. 1st and 3rd Tuesday, Sept. through May.

HIGHLAND—Glenn B. Doan, President, Greenfield; Kenneth Lyle Upp, Secretary, Greenfield. 1st Friday, monthly.

WARREN—Howard G. Berninger, President, Lebanon; D. Paul Ward, Secretary, Pleasant Plain. 2nd Tues., monthly.

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DARKE—V. Ray Boli, President, Greenville; Emmett W. Arnold, Secretary, Greenville. 3rd Tuesday, monthly, except June, July, August, December.

GREENE—Benjamin F. Lee, President, Xenia; Carl D. Hyde, Secretary, Yellow Springs. 2nd Thursday, monthly.

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MONTGOMERY—Albert V. Black, President, Centerville; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Building, Dayton 2. 1st Friday, Jan., Feb., March, April, May and November; 1st Wednesday, June, October and December.

PREBLE—E. P. Trittschuh, President, Lewisburg. Annual meeting only.

SHELBY—Thomas W. Hunter, President, Sidney; Ned A. Smith, Secretary, Sidney. 1st Tuesday, monthly.

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HARDIN—Louis A. Black, President, Kenton; William F. Binkley, Secretary, Kenton. 2nd Tuesday, monthly.

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MERCER—Donald R. Fox, President, Celina; Louis J. Finkelmeier, Secretary, Celina.

SENECA—Harry P. Ulicny, President, Fostoria; Emmet T. Sheeran, Secretary, Fostoria. 3rd Tuesday, monthly.

VAN WERT—Edwin Wm. Burnes, President, Van Wert; Norman L. Marxen, Secretary, Van Wert. 1st Friday.

WYANDOT—Richard L. Garster, President, Upper Sandusky; Allen F. Murphy, Secretary, Upper Sandusky. 2nd Tues.

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HENRY—Tony P. Delventhal, President, Napoleon; Thomas F. Tabler, Secretary, Holgate. 1st Tuesday, monthly.

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CUYAHOGA—Chester R. Jablonoski, President, Cleveland; Mr. Robert A. Lang, Executive Secretary, 2009 Adelbert Road, Cleveland 6. 2nd Tuesday, monthly.

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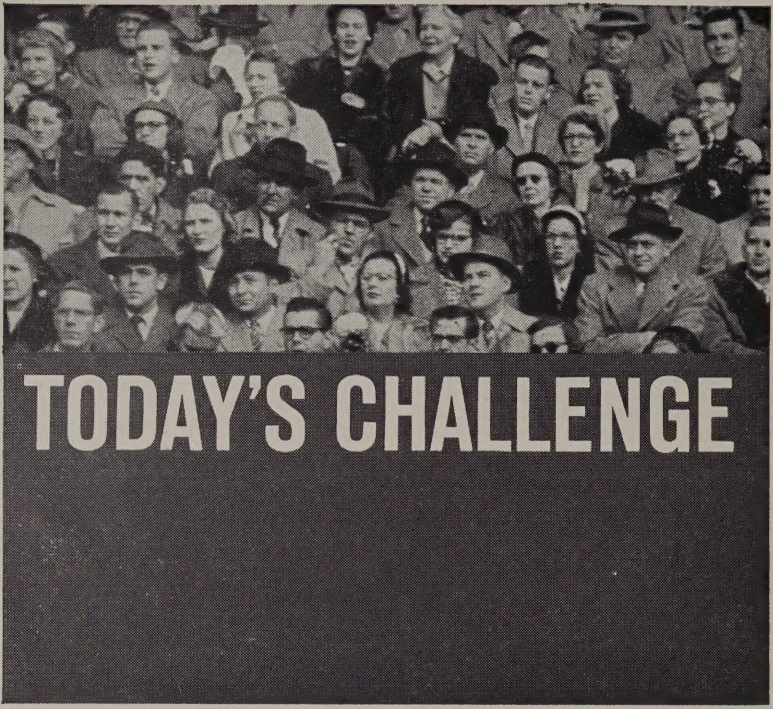

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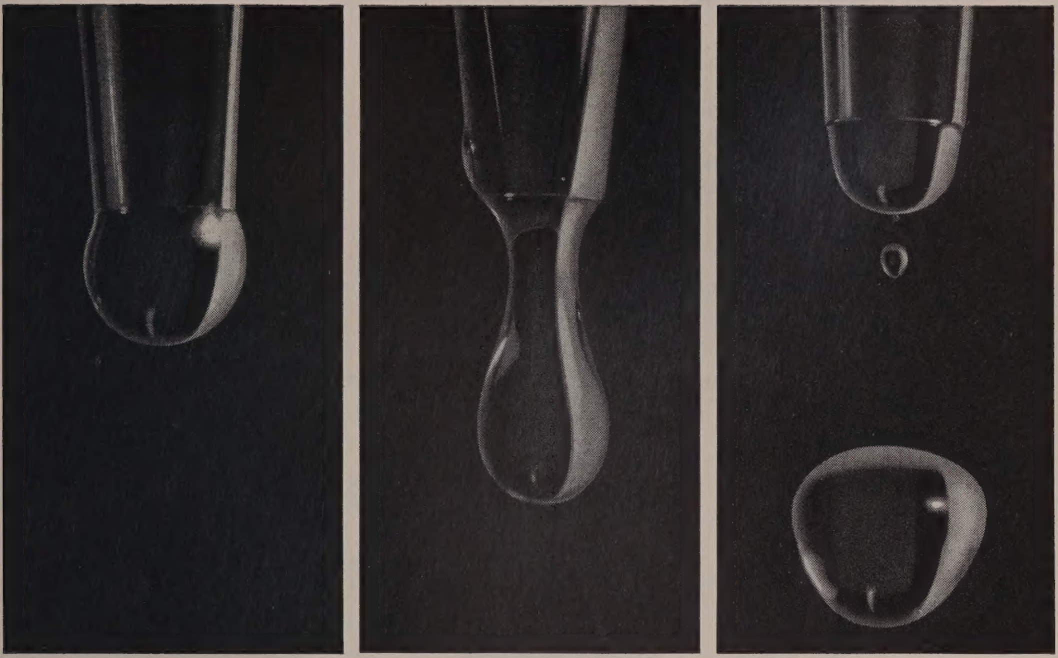

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Source—Meyer, O. O.: Northwest Med. *53*:1006, 1954.

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*Bauer, H. G.; Seegers, W.; Krawzoff, M., and McGavack, T. H.: New York J. Med. *58*:520 (Feb. 15) 1958.

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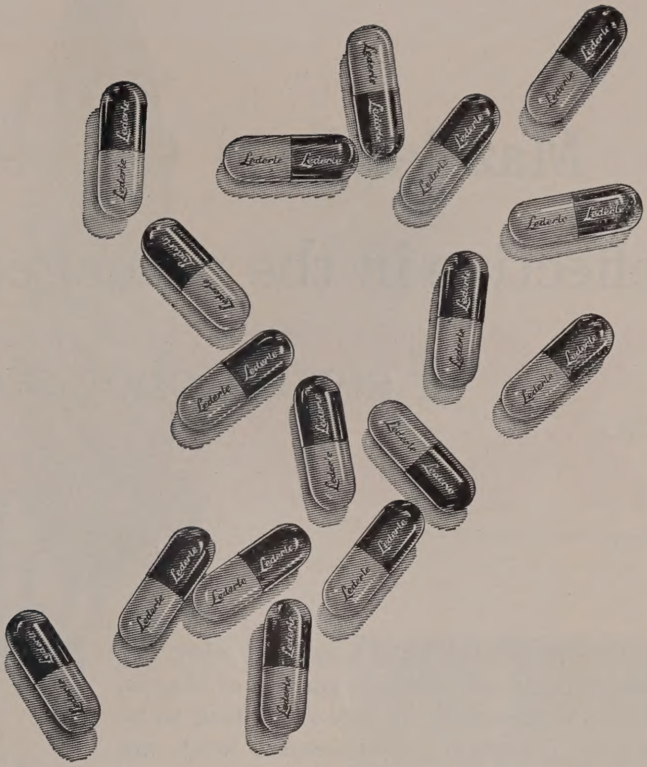

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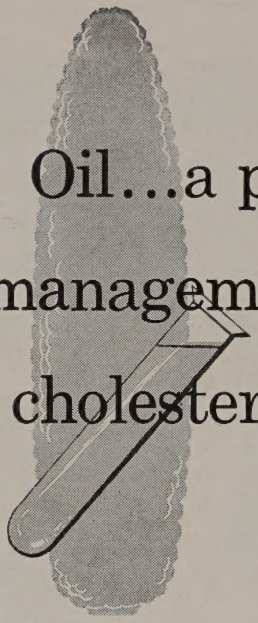

Extensive clinical tests show that when the diet contains an adequate amount of Mazola Corn Oil, serum cholesterol levels tend to be normal . . . high blood cholesterol levels are lowered, normal levels maintained.

Fortunately for both physician and patient, Mazola Corn Oil is not only rich in unsaturated fatty acids, it is also a delicious food. It becomes an enjoyable and normal part of the patient's daily meals—no complicated or special diet is required.

Here is a therapy easy for you to prescribe, easy and pleasant for your patients to follow.

Nutritional authorities generally recommend that fats should provide no more than 30% of the total calories. In cholesterol-lowering diets from one-third to one-half of these fats should be unsaturated, such as in Mazola Corn Oil.

IN COOKING OR SALADS

Mazola Corn Oil is a superlative cooking oil as well as a delicious salad oil. Adequate amounts can be eaten daily—in a wide variety of salad dressings and in a great number of fried and baked foods.

MOST EFFECTIVE

Pure, clear, bland and odorless. Mazola Corn Oil is stable and dependable, providing the full measure of cholesterol-lowering unsaturated fatty acids characteristic of corn oil.

ECONOMICAL

Mazola Corn Oil is sold in grocery stores throughout the country, is available everywhere. Its comparatively low cost makes it as economical as it is effective.

CORN PRODUCTS
REFINING COMPANY

NEW IMPROVED
golden light
Mazola
CORN OIL

MAZOLA* CORN OIL is a rich source of unsaturated fatty acids. It can form a regular part of the diet without major changes in eating habits to provide an effective unsaturated oil as a part of the daily meals.

EACH TABLESPOONFUL OF MAZOLA CORN OIL PROVIDES NOT LESS THAN:

Linoleic Acid	7.4 Gm.
Sitosterols	130 mg.
Natural Tocopherols	15 mg.

TYPICAL AMOUNTS PER DIET

For a 3600 calorie diet	3 tablespoonsful
For a 3000 calorie diet	2.5 tablespoonsful
For a 2000 calorie diet	1.5 tablespoonsful

*Reg. U. S. Pat. Off.

Low Dosage KYNEX* for G.U. Infections

Sulfamethoxypyridazine Lederle

Only
One
tablet
a
Day

Unusual Antibacterial and Anti-infective Properties—More soluble in acid urine[1] . . . higher and better sustained plasma levels than any other known and useful antibacterial sulfonamide.[2]

Unprecedented Low Dosage—Less sulfa for the kidney to cope with . . . yet fully effective. A single daily dose of 0.5 to 1.0 Gm. maintains higher plasma levels than 4 to 6 Gm. daily of other sulfonamides—a notable asset in prolonged therapy.[2]

Dosage: The recommended adult dose is 1 Gm. (2 tablets) the first day, followed by 0.5 Gm. (1 tablet) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours.

KYNEX—WHEREVER SULFA THERAPY IS INDICATED

Tablets: Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

Syrup: Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

references:

1 Grieble, H.G., and Jackson, G.G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958

2. Editorial: *New England J. Med.* 258:48-49, 1958.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

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The Physician's Bookshelf

(Books received from publishers. *The Journal* is not obligated to list herein every book received. It will try to list those which appear to be of greatest interest.)

* * *

So You Want To Be A Doctor, by Alan E. Nourse, M. D. ($2.75, *Harper & Brothers, New York 16, New York.)*

The Chemistry of Organic Medicinal Products, by Glenn L. Jenkins, W. H. Hartung. K. E. Hamlin and J. B. Data. ($10.75, Fourth Edition, *John Wiley & Sons, Inc., New York 16, N. Y.)*

Management of Endocrine Problems, by Allan C. Barnes, M. D. ($18.00, Four Volumes, *Harper & Brothers, New York 16, New York.)*

Modern Clinical Psychiatry, by Arthur P. Noyes, M. D., and L. C. Kolb, M. D. ($8.00, Fifth edition, *W. B. Saunders Company, Philadelphia 5, Pa.)*

Orr's Operations of General Surgery, by George A. Higgins, M. D., and Thomas G. Orr, Jr., M. D. ($20.00, Third edition, *W. B. Saunders Company, Philadelphia 5, Pa.)*

The Cerebrospinal Fluid; Production, Circulation and Absorption. A Ciba Symposium, by G. E. W. Wolstenholme and Cecilia M. O'Conner. ($9.00, *Little, Brown and Company, Boston 6, Massachusetts.)*

Laboratory Medicine — Hematology, by John B. Miale, M. D. ($13.75, *The C. V. Mosby Company, St. Louis 3, Missouri.)*

Health Yearbook: 1957, compiled by O. E. Byrd, M. D. ($5.50, *Stanford University Press, Stanford, California.)*

Modern Marriage and Family Living, by Morris Fishbein, M. D., and Ruby J. R. Kennedy, Ph. D. ($5.00, *Oxford University Press, New York 11, New York.)*

A Primer for Coronary Patients, by Robert J. Needles, M. D., and Edith M. Stoney. ($3.75, *Appleton-Century-Crofts Co., Inc., New York 1, New York.)*

Diseases of the Thyroid and Parathyroid Glands, by B. J. Ficarra, M. D. ($8.50, *Intercontinental Medical Book Corporation, New York 16, New York.)*

Orthopedic Diseases: Physiology, Pathology and Radiology, by Ernest Aegerter, M. D., and John A. Kirkpatrick, Jr., M. D. ($12.50, *W. B. Saunders Company, Philadelphia 5, Pa.)*

Tuberculosis in White and Negro Children: The Epidemiologic Aspects of the Harriet Lane Study; Volumes I & II. Vol. I by Janet B. Hardy, M. D., and Vol. II by Miriam E. Brailey, M. D. ($12.00 (Two Volumes), Published for The Commonwealth Fund by *Harvard University Press, Cambridge 38, Mass.)*

Medical Electrical Equipment, by Robert E. Molloy with nineteen contributors. ($15.00, *Philosophical Library, Inc., New York 16, New York.)*

Theory of Psychoanalytic Technique, by Karl Menninger, M. D. ($4.75, *Basic Books, Inc., New York 3, New York.)*

Fundamentals in Cardiology, by John B. Wild, M. D. ($4.50, *Charles C. Thomas Publisher, Springfield, Illinois.)*

Year Book of Dermatology and Syphilology 1957-1958 Series, by Rudolf L. Baer, M. D., and Victor H. Witten, M. D. ($8.00, *Year Book Publishers, Inc., Chicago 11, Illinois.)*

Fifty Years of Neurosurgery: A Personal Story, by Ernest Sachs, M. D. ($3.50, *Vantage Press, Inc., New York 1, New York.)*

Selected Writings of John Hughlings Jackson: Volume I, by James Taylor, M. D. ($15.00 (Two Volumes), *Basic Books, Inc., New York 3, New York.)*

Etiology and Treatment of Leukemia, by Walter J. Burdette, M. D. ($4.00, *The C. V. Mosby Company, St. Louis 3, Missouri.)*

Polyscience, by Frank H. Kelly, M. D. ($2.95, *Vantage Press, New York 1, New York.)*

Clinical Orthopaedics: No. 11, by Anthony F. DePalma, M. D. ($7.50, single copy, $12.00, two volumes, *J. B. Lippincott Company, Philadelphia 5, Pa.)*

Hormone Production in Endocrine Tumours: Volume 12, by G. E. W. Wolstenholme and Maeve O'Connor. ($9.00, *Little, Brown & Company, Boston 6, Massachusetts.)*

How To Live With Diabetes, by Henry Dolger, M. D., and Bernard Seeman. ($3.50, *W. W. Norton & Company, Inc., New York 3, N. Y.)*

General Pathology, by Sir Howard Florey. ($16.00, Second edition, *W. B. Saunders Company, Philadelphia 5, Pa.)*

The Esophagus; Medical and Surgical Management, by Edward B. Benedict, M. D., and George L. Nardi, M. D. ($15.00, *Little, Brown & Company, Boston 6, Mass.)*

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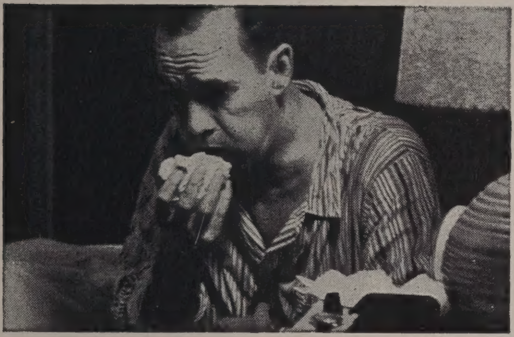
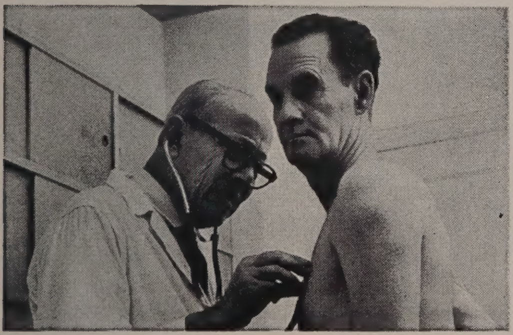
breaks up cough

even persistent cough

Patient, factory worker, age 43, had suffered for months with persistent, dry cough, which he termed "smoker's hack."



Cough frequently interrupted his sleep, causing him to be nervous, irritable; his job efficiency was impaired.



Chest X-ray was negative and the plant physician prescribed PYRIBENZAMINE EXPECTORANT with Ephedrine. Patient noticed almost immediate relief—a week later felt "considerably better."

Pyribenzamine Expectorant with Ephedrine provides a unique combination of antitussive agents, which work three ways at once to break up the persistent cough: *Pyribenzamine* relieves histamine-induced congestion throughout the respiratory tract; *ephedrine* relaxes the bronchioles and makes breathing easier; *ammonium chloride* liquefies mucus, relieving dry cough and promoting productive expectoration.

Supplied: Pyribenzamine *Expectorant with Ephedrine,* containing 30 mg. Pyribenzamine citrate (equivalent to 20 mg. Pyribenzamine hydrochloride), 10 mg. ephedrine sulfate and 80 mg. ammonium chloride per 4-ml. teaspoon. Also available: Pyribenzamine *Expectorant with Codeine and Ephedrine,* same formula as above with the addition of 8 mg. codeine phosphate per 4-ml. teaspoon (exempt narcotic).

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0.1 Gram (1½ grains) or 1 U.S.P. Digitalis Unit.
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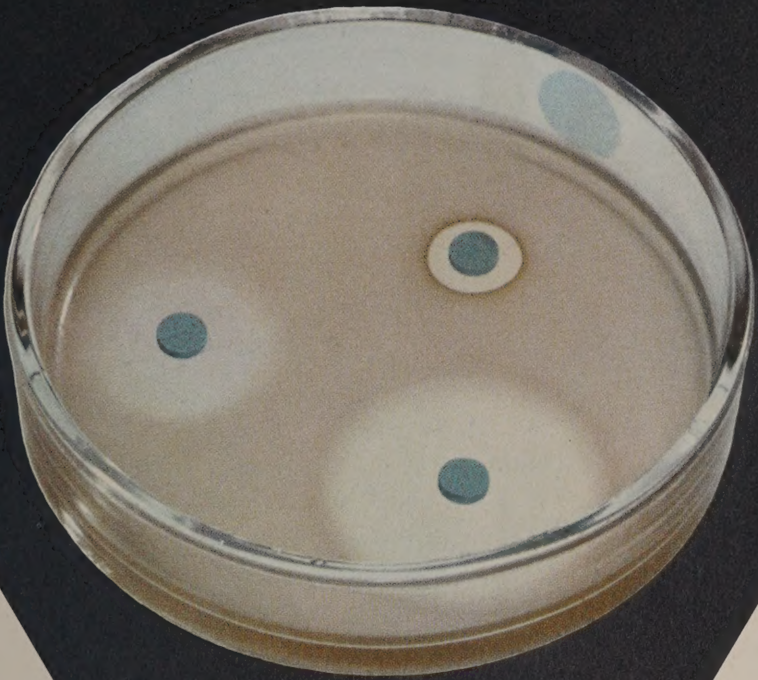

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the control
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abbott's antibiotic triad

Erythrocin®

stearate

(Erythromycin Stearate, Abbott)

against
staph-, strep-
and
pneumococci

indications:

In infections caused by staphylococci, streptococci (including enterococci) and pneumococci. Also, against organisms that have become resistant to other antibiotics. ERYTHROCIN should be used where patients are allergic to penicillin or other antibacterials.

dosage:

Usual adult dose is 250 mg. every six hours; for severe infections, usual dose is 500 mg. every six hours. Child's dose may be reduced in proportion to body weight.

supplied:

In bottles of 25 and 100 Filmtabs (representing 100 and 250 mg. of ERYTHROCIN activity). Also, in cinnamon-flavored oral suspension; 75-cc. bottles. Each 5-cc. teaspoonful represents 100 mg. of ERYTHROCIN activity.

® Filmtab—Film-sealed tablets, Abbott; pat. applied for.

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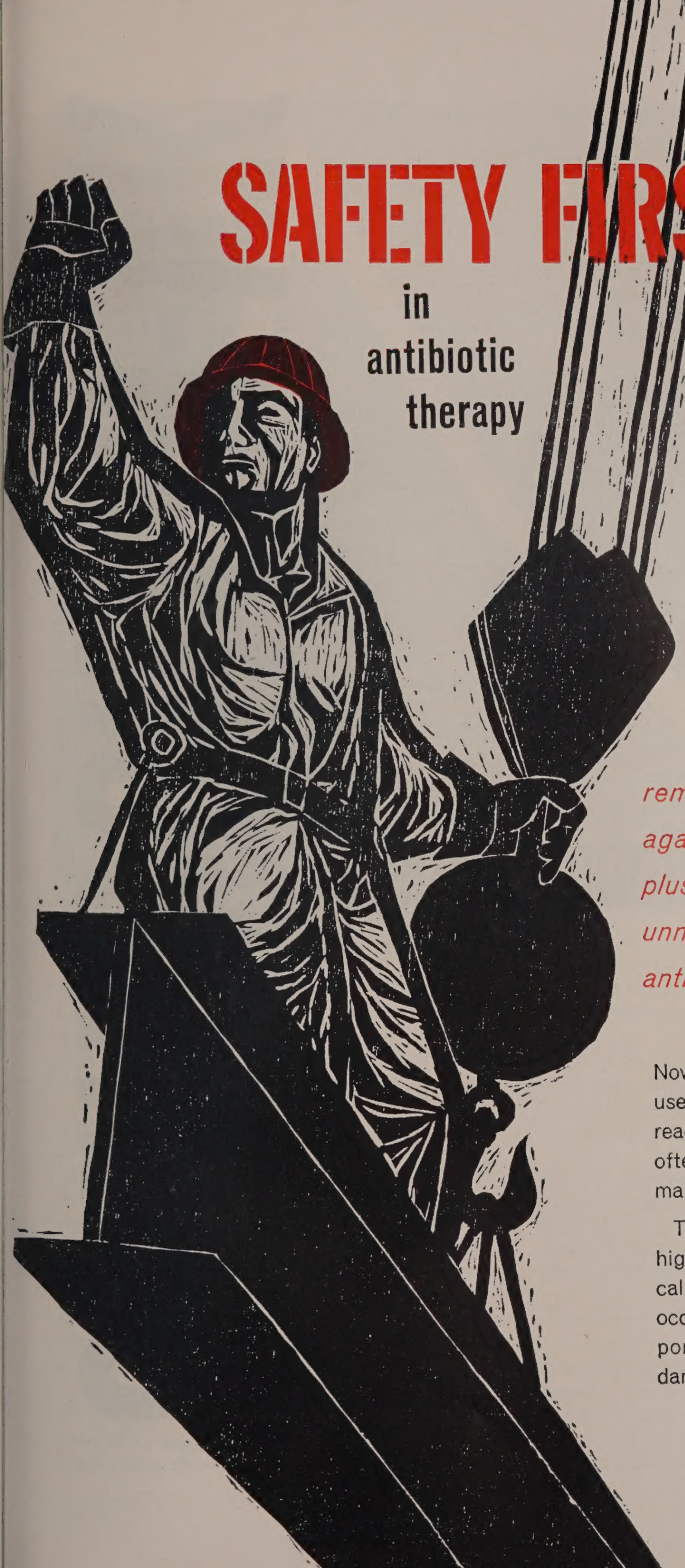

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antibiotic
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remarkable effectiveness against the cocci– plus a safety record unmatched in systemic antibiotic therapy

Now, after more than six years of extensive use, there has not been a single serious reaction to ERYTHROCIN. Additionally, the often-met problem of resistance has remained unusually low with ERYTHROCIN.

Therapeutically, you'll find ERYTHROCIN highly effective against the majority of coccal organisms. Where severe viral attacks occur, ERYTHROCIN may well be the weapon to counteract those dangerous complications.

Abbott

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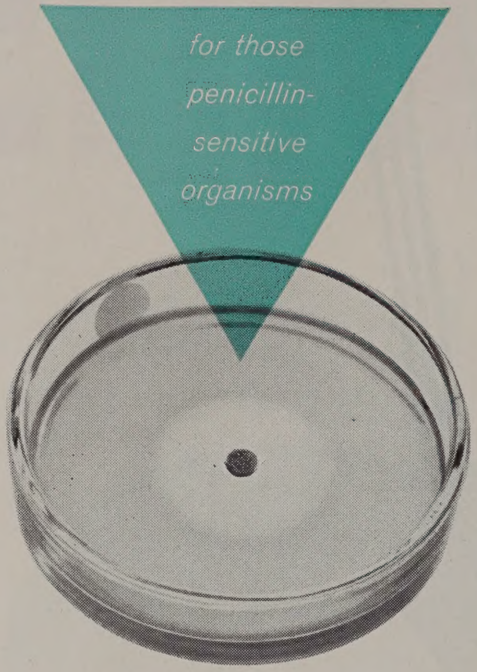

for those penicillin-sensitive organisms

the higher blood levels of COMPOCILLIN-VK®

Potassium
Penicillin V

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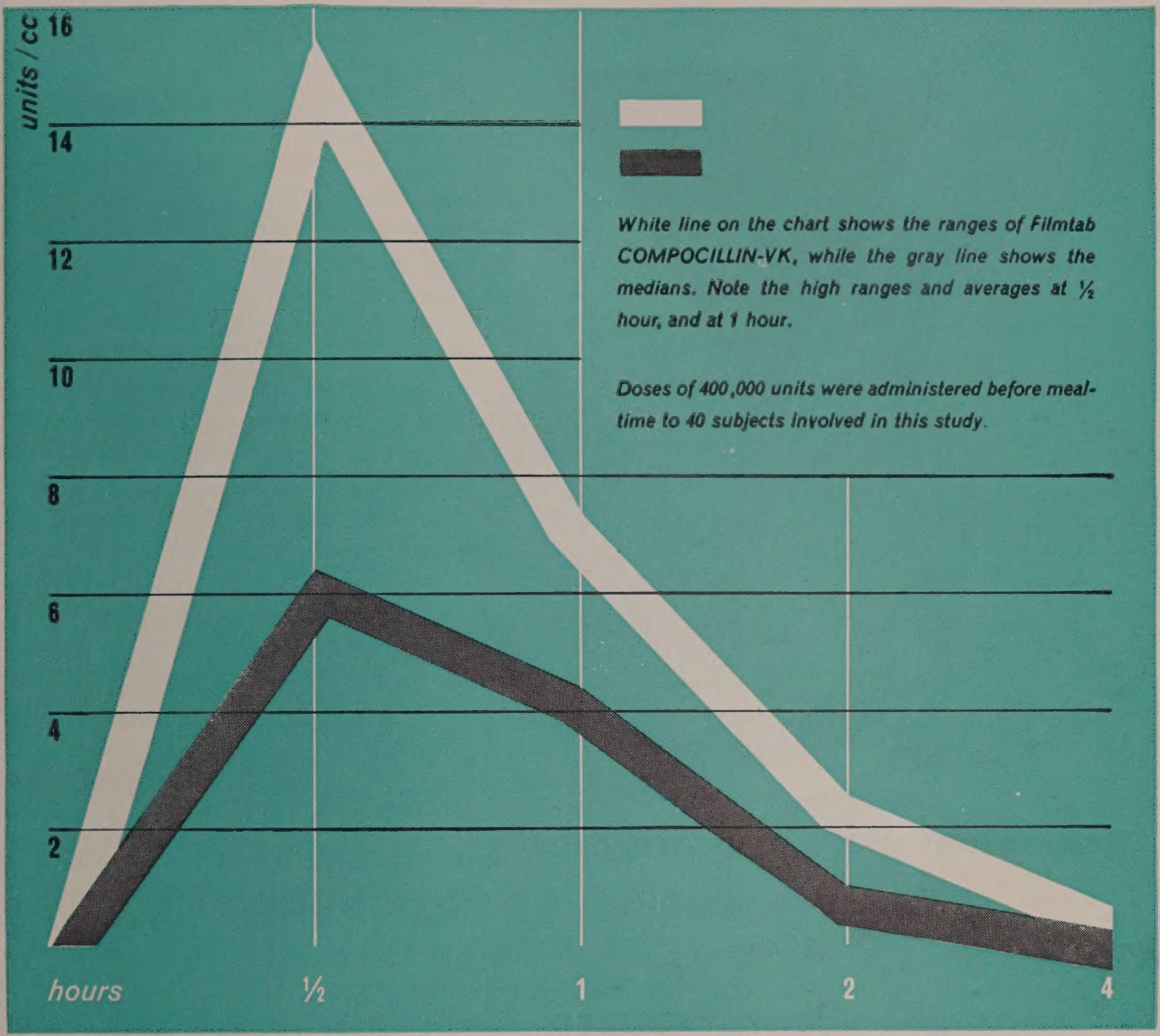


White line on the chart shows the ranges of Filmtab COMPOCILLIN-VK, while the gray line shows the medians. Note the high ranges and averages at ½ hour, and at 1 hour.

Doses of 400,000 units were administered before mealtime to 40 subjects involved in this study.

NOW, IN BOTH FILMTAB AND ORAL SOLUTION, patients get high penicillin V blood levels with COMPOCILLIN-VK. Note the chart. Concentrations are three times higher than an equivalent dose of potassium penicillin G.

COMPOCILLIN-VK is indicated whenever you desire oral penicillin therapy. In severe infections, oral penicillin should be supplemented by parenteral therapy to obtain the maximum therapeutic response.

Indications:

Against all organisms sensitive to oral penicillin therapy. For prophylaxis and treatment of complications in viral conditions. And as a prophylaxis in rheumatic fever and rheumatic heart disease.

Dosage:

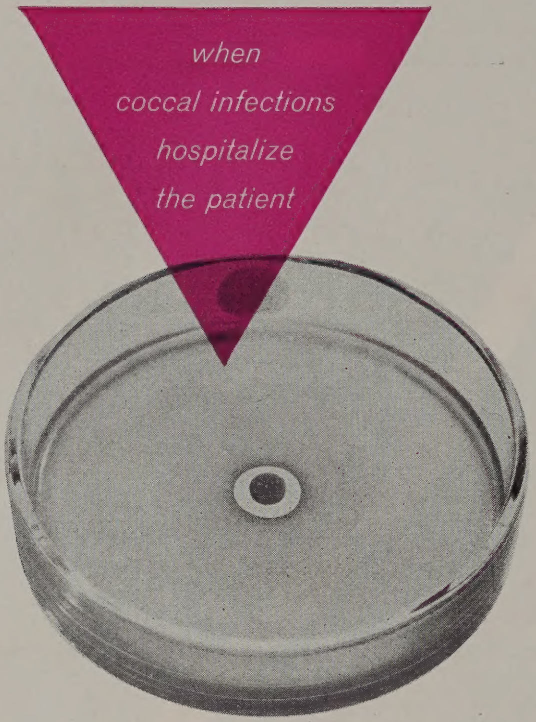
Depending on the severity of the infection, the usual adult dose is 125 to 250 mg. (200,000 to 400,000 units) every four to six hours. For children, dosage may be reduced in proportion to body weight.

Supplied:

In Filmtabs, representing 125 mg. (200,000 units) of potassium penicillin V, bottles of 50 and 100. In 250 mg. (400,000 units), bottles of 25 and 100.

For Oral Solution, COMPOCILLIN-VK comes in dry granules for easy reconstitution with water. Cherry-flavored, the granules come in 40-cc. and 80-cc. bottles. Each 5-cc. teaspoon of solution represents 125 mg. (200,000 units) of potassium penicillin V.

COMPOCILLIN-V® Oral Suspension (Ready-Mixed), Hydrabamine Penicillin V, Abbott, comes in 40-cc. and 80-cc. bottles. Each tasty, banana-flavored 5-cc. teaspoonful represents 180 mg. (300,000 units) of penicillin V. At all pharmacies. Abbott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coccal infections
hospitalize
the patient

the most effective antibiotic available against staphylococci

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(RISTOCETIN, ABBOTT)

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Provides Outstanding Clinical Effectiveness Against Coccal Infections, Including Resistant Staphylococci and Enterococci[1]

Provides Bactericidal Action Against Coccal Infections[1]

Provides Successful Short-Term Therapy In Endocarditis[2]

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Now, after just 12 months, SPONTIN has become an outstanding drug of choice against resistant staphylococci, and in other serious coccal infections.

Six papers presented at the Antibiotics Symposium[1] reported the effectiveness of SPONTIN against resistant staphylococcal infections. Clinical reponses involved enterococcal endocarditis, staphylococcal pneumonias and staphylococcal bacteremias. Many of these patients were going downhill steadily—in spite of treatment by other antibiotics.

Toxicity? Careful attention to dosage recommendations has practically eliminated toxicity and side effects as serious obstacles to therapy. Also, recent improvements have been made in the manufacture of SPONTIN; the drug is now made from pure crystals. A recent report[3] in the Journal of the American Medical Association concluded, "It is our opinion that, if proper precautions are observed, ristocetin is a safe and potent agent to employ in the treatment of staphylococcal infections."

If you do not have the revised literature on this lifesaving antibiotic, please contact your Abbott Representative soon; or write direct to Abbott Laboratories, North Chicago, Illinois.

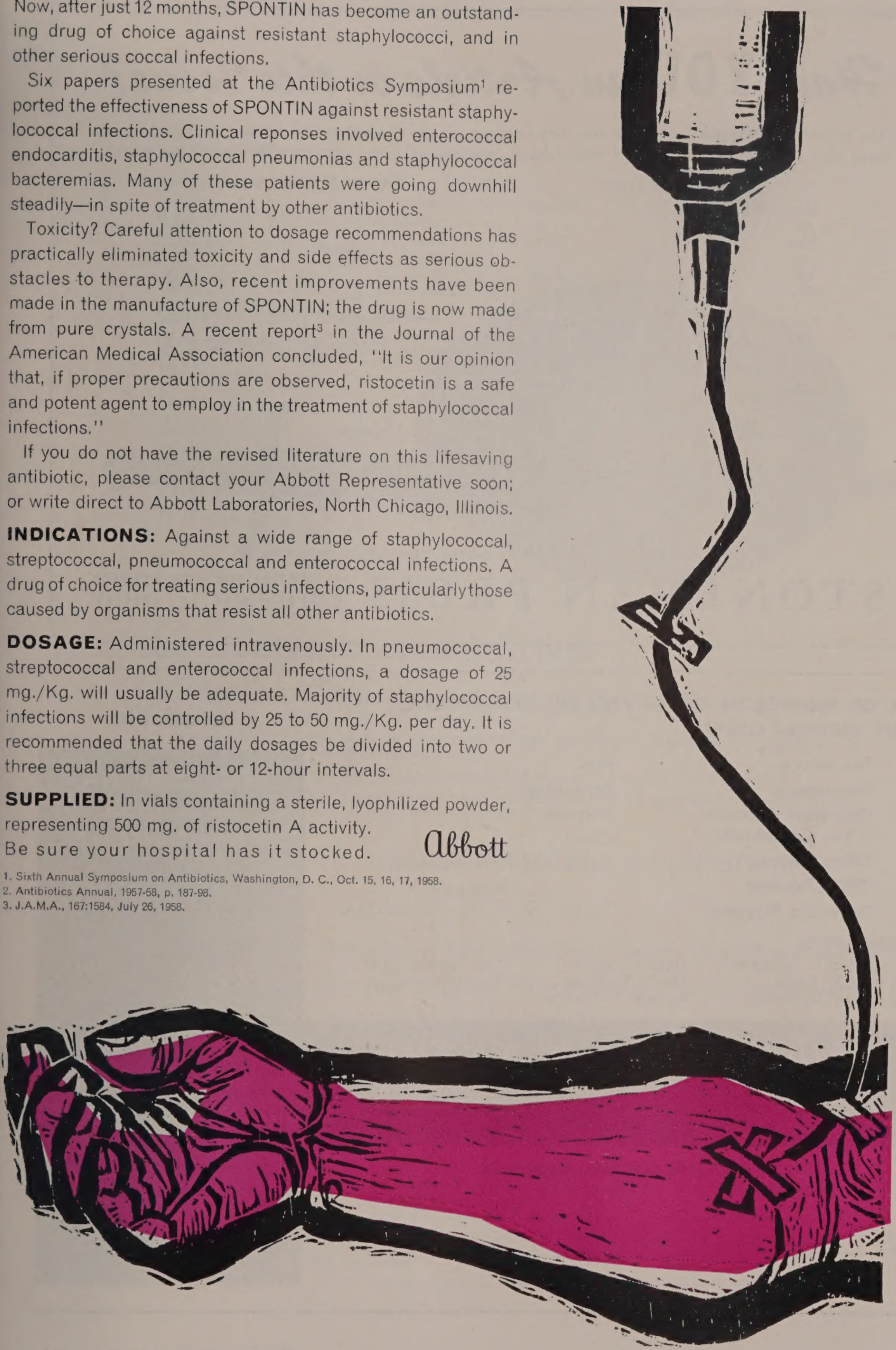
INDICATIONS: Against a wide range of staphylococcal, streptococcal, pneumococcal and enterococcal infections. A drug of choice for treating serious infections, particularlythose caused by organisms that resist all other antibiotics.

DOSAGE: Administered intravenously. In pneumococcal, streptococcal and enterococcal infections, a dosage of 25 mg./Kg. will usually be adequate. Majority of staphylococcal infections will be controlled by 25 to 50 mg./Kg. per day. It is recommended that the daily dosages be divided into two or three equal parts at eight- or 12-hour intervals.

SUPPLIED: In vials containing a sterile, lyophilized powder, representing 500 mg. of ristocetin A activity.
Be sure your hospital has it stocked.

Abbott

1. Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct. 15, 16, 17, 1958.
2. Antibiotics Annual, 1957-58, p. 187-98.
3. J.A.M.A., 167:1584, July 26, 1958.



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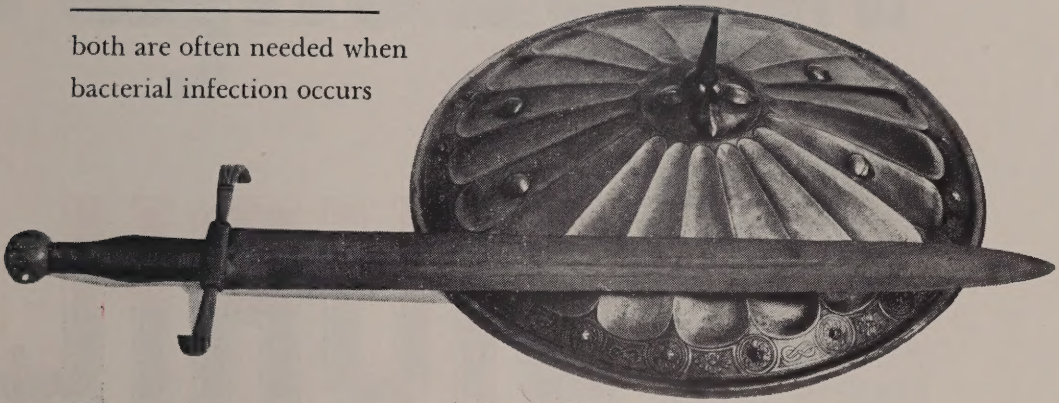
both are often needed when bacterial infection occurs



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Mysteclin-V contains tetracycline phosphate complex

It provides a direct strike at all tetracycline-susceptible organisms (most pathogenic bacteria, certain rickettsias, certain large viruses, and Endamoeba histolytica).

It provides the new chemical form of the world's most widely prescribed broad spectrum antibiotic.

It provides unsurpassed initial blood levels – higher and faster than older forms of tetracycline – for the most rapid transport of the antibiotic to the site of infection.

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Squibb Tetracycline Phosphate Complex (Sumycin) and Nystatin (Mycostatin)

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FINNERTY, F. A., Buchholz, J. H. and Tuckman, J.: J.A.M.A. **166**:141, Jan. 11, 1958.

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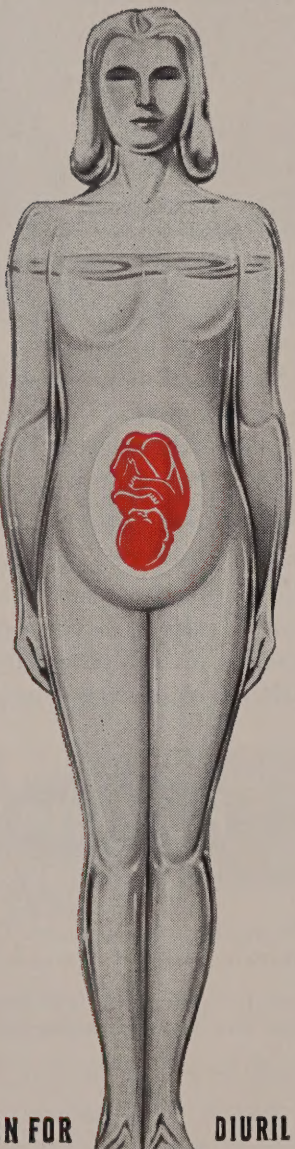

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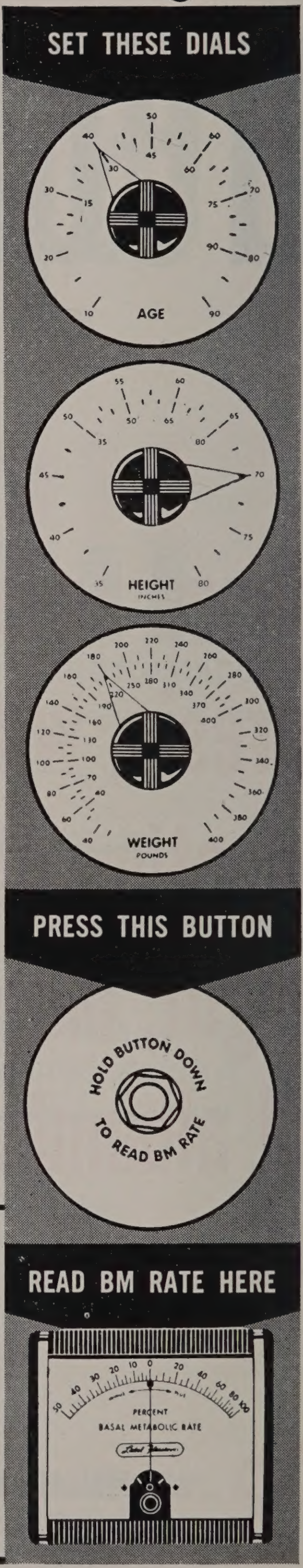
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HEIGHT
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WEIGHT
POUNDS
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HOLD BUTTON DOWN TO READ BM RATE
READ BM RATE HERE
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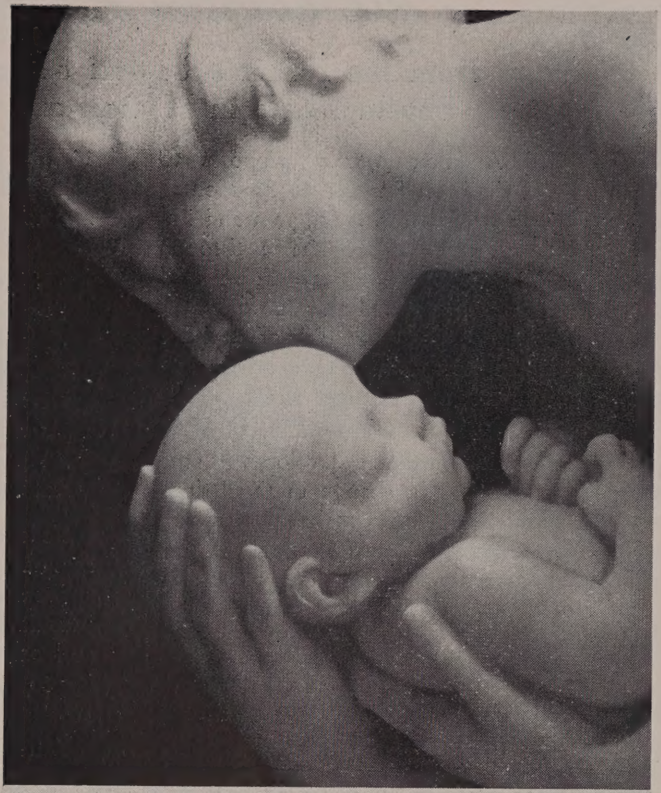

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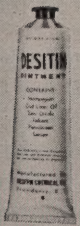

Washington Roundup . . .

News from the Nation's Capital of Interest to Physicians; Developments in Medical and Health Fields

New Federal Aviation Agency proposes to establish post of Civil Air Surgeon to function as director of civil aviation medical program and improvement of safety in air commerce through sound medical knowledge and research in civil aviation. AMA has advocated this move as the first step in obtaining adequate number of qualified medical examiners for airmen and other personnel, in the interest of passenger safety.

* * *

In another aviation medicine development, the Federal agency proposes a change in regulations that would permit airliners to make unscheduled stops in order to provide transportation for persons in need of emergency medical treatment. Present "closed door" policy prohibits unscheduled stops.

* * *

Recent pamphlet issued by AFL-CIO places Forand Bill passage high on list of labor's major objectives in forthcoming session of Congress.

* * *

Veterans Administration plans major new emphasis on studies of mental and physical deterioration associated with aging. VA also had mapped research programs in mental illness, cancer, heart and blood vessel disorders, tuberculosis, and development of new techniques in atomic medicine.

* * *

Unless there is a marked increase in the production of physicians and other health personnel, "not only the total (medical) research effort but the health services of the nation will be severely hampered in the years ahead," Dr. A. C. McGuinness, special assistant to HEW Secretary Flemming, said in an American College of Preventive Medicine address.

* * *

PHS Surgeon General Burney reports Asian influenza outbreaks are expected during this winter but probably with fewer cases than last winter's epidemic. He adds that a new polyvalent vaccine for the disease has been developed.

* * *

Internal Revenue Service has ruled that expenses incurred by a taxpayer in maintaining his mentally retarded son in a home that cares for such cases, such confinement being recommended by a physician, are deductible. The patient had suffered brain damage in childhood and at age 13 his doctor concluded he was so severely disturbed that it was neither safe nor practical for him to remain with his parents.

* * *

Since last winter's campaign aimed at getting more people inoculated with Salk vaccine fell short of its goal, Public Health Service plans to resume the public educational program, with cooperation of AMA, Advertising Council, National Foundation, state and local health departments and private groups.

* * *

Federal funds for Hill-Burton program in 1959 are not expected to reach $187 million record appropriation by Congress in 1958 since that appropriation was made as an anti-recession move and economic conditions have improved, according to Hill-Burton sources.

* * *

American Thrift Assembly has completed plans for action to obtain passage of Keogh bill in 1959, and already is reported contacting members of Congress. Bill would allow self-employed to defer income taxes on a percentage of their earnings if placed in retirement plans.

* * *

New Air Force surgeon general is Major Gen. Oliver Niess, succeeding Major Gen. Dan C. Ogle, who retired December 1, after 30 years of service. General Ogle was instrumental in establishing the Aeromedical Research Center, Brooks Air Force Base, and in constructing 170 new medical facilities throughout the world.

* * *

Washington, D. C. area Blue Shield group, at request of D. C. Medical Society, is studying possibility of setting up a separate medical-surgical care plan for low income groups, including the aged, that would provide regular benefits at a reduced premium. Hospitalization would not be covered.

* * *

GI-trained veterans have helped raise the entire educational level of the United States, a Veterans Administration report states. Census Bureau report indicates that the average head of the household today has 10.4 years of schooling compared with only 9 years in 1950. The Census Bureau attributed the rise largely to the educational benefits of the two GI Bills.

Relieve moderate or severe pain

Reduce fever

Alleviate the general malaise of upper respiratory infections

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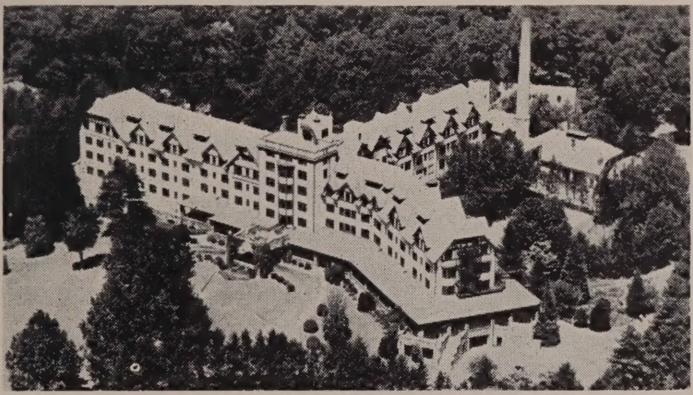

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You and Your Public . . .

Survey Shows Public's Interest in Medical News Is Extensive and Most Likely To Increase

THE physician frequently surprised (and sometimes irritated) by a patient's questions concerning the latest developments in medicine can expect this practice to continue and to expand, if news media heed the soundings of a recent survey.

The survey, conducted on behalf of the National Association of Science Writers, showed that 37 per cent of a nationwide sampling of 1,191 adults read all medical news in the newspapers. Further, 42 per cent said they wanted newspapers to print more medical and scientific news. Even if it meant omitting items concerned with other types of news, 66 per cent said, there should be more space allocated for medicine and science.

Ohio physicians can expect even more of their patients to express interest in such news. The survey indicated that 76 per cent of Midwest residents queried recalled reading specific medical items, while the nationwide average was 69.7 per cent.

Medical News Remembered

It also is interesting to note that an analysis of the survey questionnaires strongly showed that the patient is more than likely to remember medical news once he has read it. This was brought out by four so-called touchstones used by the pollsters.

Those touchstones were polio vaccine, a space satellite, radioactive fallout and fluorides in drinking water.

Some 88 per cent recalled the vaccine, 51 per cent recalled fluoridation, 53 per cent, radioactive fallout, and 23 per cent, satellites.

To substantiate, or perhaps strengthen, these conclusions that such news is read and remembered, let's take a look at the results of a newspaper poll of readers in the Minneapolis area.

The same four touchstone questions were used, with 98 per cent recalling polio vaccine information, 96 per cent recalling space satellite news, 91 per cent, radioactive fallout, and 88 per cent, water fluoridation.

The conclusion drawn by the National Association of Science Writers survey is as follows:

"Appreciation of science in a twentieth century democracy may involve life or death. It is important for Americans to understand what scientists are trying to do and what they are doing.

Huge Reservoir of Interest

"This survey has established that there is a huge reservoir of public interest in science reporting, with many readers, listeners, and viewers willing to give up other news and entertainment features to become better informed about science.

"Media executives might well 'give the public what it wants' and increase their coverage of science developments. With more and more students going through high school and on to college, and with many of them studying science, the market for science coverage in the popular communications channels certainly will expand tremendously in the years ahead.

"Much of the information in the mass media does get through to the public mind and, if the respondents in this survey are typical (and they should be), an impressive amount of this science information is remembered and can be 'played back.'

Improvement Sought

"As some scientists are seldom hesitant to proclaim, there is room for improvement in the popular reporting of scientific developments. Most people in communications concede this. Many are trying to do something about it.

"Reporters and script writers, given more training and more time in assignments, would be able to provide more details, greater background, better interpretation, and, it is hoped, higher accuracy. Such changes might help correct present distortions in the public image of science and scientists (this includes medical science) and promote the idea that they are a part of, not divorced from, contemporary living. Thus the story of science would be more properly recorded and Americans would have information on which to decide more intelligently those public matters involving science, scientists—and possibly their own existence."

What It Means To Medicine

Those are the conclusions of the science writers. Bearing in mind that the physician's public includes his patients and his fellow citizens, the following are some long range developments that the medical profession can expect:

1. News media will gradually enlarge and improve its coverage of medical and other scientific developments.

2. There will be an even greater reader (and patient) interest in medical news.

3. The physician therefore can expect not less

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but more questioning from his patients and his fellow citizens concerning medical developments.

4. News media will call more and more on the local medical profession for information and interpretation of information pertaining to medicine. This also can mean more "depth reporting," and physicians would do well to help the interpretative reporter in order that he avoid "getting out beyond his depth."

WHAT TO WRITE FOR

Some booklets, pamphlets and other published material available for the asking or at nominal expense and suitable for the physician's office, library or waiting room, or for his personal information.

* * *

Information for Physicians. This pamphlet outlines the expanded program of The National Foundation for Infantile Paralysis, now known simply as The National Foundation. Write The National Foundation, 301 East 42nd Street, New York 17, New York.

* * *

Preliminary Guide for Measuring Work Absence Due to Illness and Injury. This guide is prepared for industrial health committees and physicians who serve as industrial consultants. Write AMA Council on Medical Service, 535 North Dearborn Street, Chicago 10, Illinois.

* * *

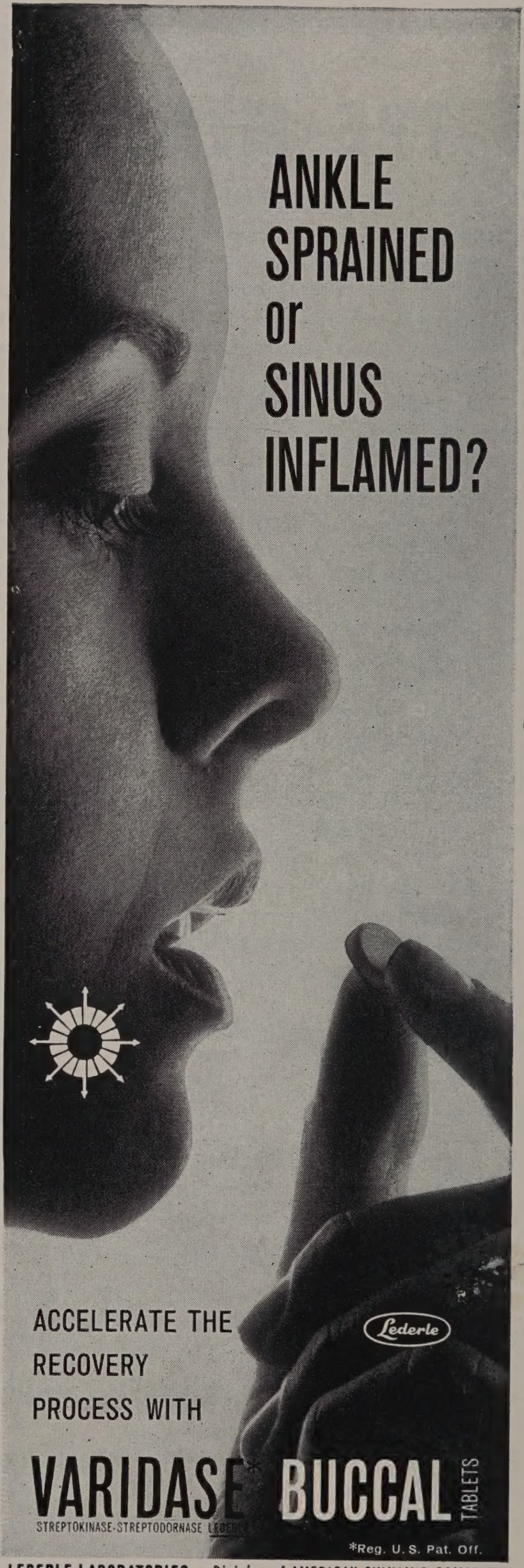
Summary Report on Health and Insurance Plans under Collective Bargaining, Late 1955. For physicians interested in coverage in and provisions of insurance plans under collective bargaining. Write AMA Council on Medical Service, 535 North Dearborn Street, Chicago 10, Illinois.

* * *

For Mother and Dad and The Time Dede Went To The Hospital. These two pamphlets which Columbus Children's Hospital distributes to parents and hospitalized children provide a wealth of information for the parents and a fascinating pictorial guide for the child facing hospitalization. Write Children's Hospital, 561 South 17th Street, Columbus 5, Ohio.

* * *

Safe Handling of Bodies Containing Radioactive Isotopes. National Bureau of Standards has published this 20-page guide for surgeons, pathologists and funeral directors. 15 cents. Write Superintendent of Documents, Government Printing Office, Washington 25, D. C.



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Capsules / Oral Suspension

designed for effective control of common gram-positive infections

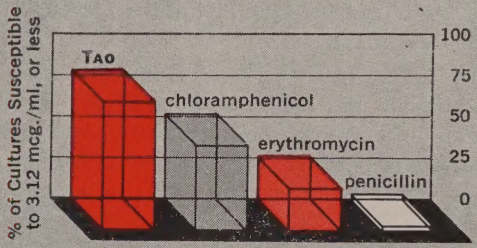
effective . . .

CLINICAL RESULTS	adults	children	all Staph infections
Cured	172 (80%)	148 (89%)	71 (88%)
Improved	28 (13%)	8 (5%)	7 (9%)
Failure	17 (7%)	11 (6%)	3 (3%)

Types of infecting organisms: The majority of identified etiologic microorganisms were Staph. aureus and Staph. albus. Tao has its greatest usefulness against organisms such as: staphylococci (including strains resistant to other antibiotics), streptococci (beta-hemolytic strains, alpha-hemolytic strains and enterococci), pneumococci, gonococci, Hemophilus influenzae.

even against resistant staph[1,2] . . .

Per cent of "antibiotic-resistant" epidemic staphylococci cultures susceptible to Tao, erythromycin, penicillin and chloramphenicol.[1]



well tolerated . . .

REACTIONS:

(a) adults	**(b) children**
Total—9.2% (20 out of 217)	Total—0.6% (1 out of 167)
Skin rash—1.4% (3 out of 217)	Skin rash—none
Gastrointestinal—7.8% (17 out of 217)	Gastrointestinal—0.6% (1 out of 167)

There was complete freedom from adverse reactions in 94.5% of all patients. Side effects in the other 5.5% were usually mild and seldom required discontinuance of therapy.

plus . . . stability in gastric acid • rapid, high and sustained blood levels • high urinary concentrations • outstanding palatability in a liquid preparation.

Dosage and Administration: Dosage varies according to the severity of the infection. For adults, the average dose is 250 mg. q.i.d.; to 500 mg. q.i.d. in more severe infections. For children 8 months to 8 years of age, a daily dose of approximately 30 mg./Kg. body weight in divided doses has been found effective. Since Tao is therapeutically stable in gastric acid, it may be administered at any time, without regard to meals.

Supplied: Tao Capsules—250 mg. and 125 mg.; bottles of 60. Tao for Oral Suspension—1.5 Gm.; 125 mg. per teaspoonful (5 cc.) when reconstituted; unusually palatable cherry flavor; 2 oz. bottle.

References: 1. English, A. R., and Fink, F. C.: Antibiotics & Chemother. (Aug.) 1958. 2. English, A. R., and McBride, T. J.: Antibiotics & Chemother. (Aug.) 1958. 3. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy (Aug.) 1958. 4. Celmer, W. D., et al.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 476.

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*TRADEMARK

In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

DO'S AND DON'TS ABOUT HYPNOSIS

Hypnosis appears to be the magic word of the day. More and more patients are demanding its use. More and more doctors—confused over the claims and counter-claims regarding it—are appealing to medical authorities for authentic advice as to its effectiveness.

All seeking advice will find a report of the Council on Mental Health of the American Medical Association on the medical use of hypnosis extremely valuable.

The conclusions of the report, which was approved by the AMA Board of Trustees and House of Delegates, contains these pertinent recommendations and warnings:

"General practitioners, medical specialists, and dentists might find hypnosis valuable as a therapeutic adjunct within the specific field of their professional competence. It should be stressed that all those who use hypnosis need to be aware of the complex nature of the phenomena involved.

"Teaching related to hypnosis should be under responsible medical or dental direction, and integrated teaching programs should include not only the techniques of induction but also the indications and limitations for its use within the specific area involved. Instruction limited to induction techniques alone should be discouraged.

"Certain aspects of hypnosis still remain unknown and controversial, as is true in many other areas of medicine and the psychological sciences. Therefore, active participation in high-level research by members of the medical and dental professions is to be encouraged. The use of hypnosis for entertainment purposes is vigorously condemned."

WHY SHOULD FEDERAL HOSPITALS BE TEACHING UNITS?

Commenting recently on certain Medicare Matters, *California Medicine,* official magazine of the California Medical Association, came up with these observations regarding the military hospitals, which observations, in our opinion, make a lot of sense:

"In recent years the federal hospitals operated by the Army, Navy, Air Force and Veterans Administration have enlarged this concept and put themselves in the position of being essential teaching units, purportedly as a means of improving the training of their own medical officers.

"It is easily understandable that military officials are sincerely interested in securing more extensive training for their staff physicians. But such training can be secured through the numerous private hospitals all over the country which today have a shortage of residents in all branches of medicine.

"With surplus residencies in private institutions, why should government add to the total of available residencies by setting up training programs of its own? In so doing, government adds to the vicious cycle of assuming the care of more patients, securing physicians to provide the care, building more beds to handle the patients, using the patients as teaching material and drafting more physicians as clinicians and teachers."

FIVE CHANCES AT LEAST TO DO PR WORK

The average citizen sees his doctor about five times during the year, according to data being compiled in the National Health Survey conducted by the US Public Health Service.

This means that most physicians have five opportunities annually to acquaint each of their patients about some of the opinions and problems of the medical profession. These chances should not be overlooked. They offer the physician an opportunity to be his own public relations agent.

TIME FOR YOU TO BE A CC MEMBER

In recent years tall tales of, by and about Texas and Texans are good for sure-fire laughs in just about any social gathering. An item in a recent A. M. A. Secretary's letter certainly is not in that category. It relates an accomplishment of which the medical profession in the largest city of the Great State of Texas has a right to crow! Here it is:

"Did you know that the Dallas Chamber of Commerce has more physician members than any other chamber in the United States?

"Membership of doctors in the Dallas chamber has grown from 92 in 1953—when only three served on chamber committees—to a total of 340 in 1958, with 34 actively serving on committees."

While we are not in position to substantiate such a claim for an Ohio city, we do know that many Ohio doctors are members of local cham-

nasal and paranasal congestion and control secondary invaders

Now, a single unique preparation, Trisulfaminic, can provide dramatic relief from congestion, and at the same time protect the patient from secondary bacterial invaders. Often within minutes of the first dose, congestion begins to clear; the patient can breathe again.

Trisulfaminic is particularly valuable for the "almost well" patient who is recovering from influenza but is left with congested nasal and bronchial passages. And for patients with purulent rhinitis, sinusitis or tonsillitis, combination therapy with Trisulfaminic offers a most realistic approach to total treatment.

Oral Decongestant Action. Through the action of Triaminic, nasal patency is achieved rapidly and dramatically. Adequate ventilation helps eliminate mucus-harbored pathogens. And because Trisulfaminic is administered *orally*, there is no problem of rebound congestion, no pathological change wrought in the nasal mucosa.

Wide-Spectrum Action. Secondary bacterial infections, which are always a threat in upper respiratory involvement, are forestalled by the wide-spectrum effectiveness of triple sulfonamides. This added antibacterial protection makes Trisulfaminic highly useful in treating the debilitated patient who is prone to lingering or frequently recurring colds.

Trisulfaminic *tablets and suspension*

TRIAMINIC PLUS TRIPLE SULFAS

Each Tablet and each 5 ml. teaspoonful of Suspension contains:

Triaminic®	25 mg.
(phenylpropanolamine HCl	12.5 mg.;
pheniramine maleate	6.25 mg.;
pyrilamine maleate	6.25 mg.)
Trisulfapyrimidines U.S.P.	0.5 Gm.

Dosage: Adults—2 to 4 tablets or teaspoonfuls initially, followed by 2 tablets or teaspoonfuls every 4 to 6 hours until the patient has been afebrile for 3 days. Children 8 to 12 years—2 tablets or teaspoonfuls initially, followed by 1 tablet or teaspoonful every 6 hours. Younger children—dosage in proportion.

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska • Peterborough, Canada

bers of commerce. We recall one prominent Ohio physician who made an outstanding record as president of the chamber in his home-town. Recently 14 individuals and businesses joined the Akron Chamber of Commerce. Four were physicians.

Evidence of community interest makes for better public relations for medicine. Doctors are citizens too! It behooves them to support and actively participate in local organizations dedicated to community progress and betterment.

If you are not now a member of your local chamber of commerce, give the secretary a buzz, and ask him about becoming a "professional member."

KNOW YOUR PATIENT WHEN NARCOTICS ARE INVOLVED

See by the newspapers that a woman narcotics addict has been taking physicians for a ride in a number of Ohio counties. She obtained prescriptions from at least 17 different physicians. She sold some of the dope; took part of it herself.

Naturally, the narcotics inspectors are not too pleased at this laxity on the part of so many physicians.

True, it may be difficult for a physician to distinguish between a legitimate need of a patient and imitation. Nevertheless, physicians must know their patients better than that. Certainly they shouldn't run the risks involved in passing out prescriptions for narcotics to every Tom, Dick and Harry.

Better investigate before writing that narcotics prescription!

WHERE DOCTORS MUST GET IN AND PITCH

In our opinion two of the best articles which have been produced todate on the general subject of health services and health problems of school-age children appeared not too long ago in the *AMA Journal.* We recommend them as "must" reading by all physicians. Both offer challenges to physicians.

One article, written by Thomas E. Shaffer, M. D., Columbus, Ohio, chairman of the OSMA Committee on School Health, relates to the health services which school-age children need. It concludes with this pertinent paragraph:

"Continuity of health services is always necessary. The child's physician, who will be called on with increasing frequency for medical examinations, advice, and treatment, will always be the connecting link between medical services, the child's family, and the community organizations, of which the school is the most important. This is a role physicians should welcome, for it improves on the older concept of overly developed health services in the schools. However, this responsibility cannot be met without an understanding of the physical and emotional problems of school-age children."

The second article, written by John L. Reichert, M. D., Chicago, discusses competitive athletics for pre-teen-age children. Dr. Reichert's conclusions, as follows, should be a red flag to both educators and members of the medical profession:

"It is apparent that today's athletic programs suffer from a lack of competent medical advice and supervision. More objective and qualified medical research is needed. More doctors, interested in children and informed on the basic facts of juvenile athletics, are needed to provide medical supervision for school and community athletic programs for preteenagers. If we as physicians are to work toward our stated goal of leading children to secure, responsible, and well-adjusted manhood and womanhood, here is an area where we must get in and pitch."

BETTER CHECK BEFORE YOU SUE

Before you sue for a fee, better be sure the weight of the evidence is on your side and, especially, that the patient you're suing has no complaint regarding the professional care received.

That's the essence of some good advice published in a recent issue of *The Doctor and the Law,* a medico-legal newsletter issued by Callaghan & Co., Chicago, and edited by George E. Hall.

Read the entire article. It's not long but contains some excellent warnings and suggestions for every physician. Quoting:

> "One of the leading plaintiff lawyers in the San Francisco Bay area, who spends almost his entire time representing claimants in medical malpractice situations, said that in his experience about 50 per cent of the clients who ask him to file a malpractice case are motivated to do so by a doctor who has sued for what to them is an unreasonable fee. In nine out of ten instances this attorney is convinced that there has been no malpractice and he talks the client out of suing. He feels, however, that doctors are lax in explaining to their patients the difficulties of their particular case and in pointing out some of the serious results which might occur even in the absence of negligence. He believes, also, that it is the doctor, not the lawyer, who should assume the obligation of telling the patient the whole story and convincing him that all was done that could have been done. He therefore offers this very sensible suggestion.
>
> "In every case in which the result was something less than the patient had hoped it would be, the doctor should make a careful and thorough explanation of all the difficulties encountered and of why a perfect result was not obtained. He should then send one bill for the reasonable value of the services rendered. (Not to send any bill might be interpreted as an admission that something was wrong.) If the bill is paid, all right. If it is not, forget the whole thing. To harass a patient who has been dissatisfied with the care given is more likely to result in the filing of a malpractice suit than in the collection of the fee. Most patients, this attorney feels, want to trust and believe their doctor. They are hurt when they get the impression that his primary concern is the collection of his fee. In most cases, a reasonable explanation is all that is necessary."

If you were to examine these patients

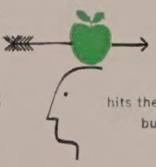
could you
detect
the asthmatic on
Medrol*? Probably not. Not without a history.

First, because he's more than likely symptom-free.

Second, because he shows none of the disturbing changes in appearance, behavior or metabolism sometimes associated with corticotherapy.

Even your practiced clinical eye would find it difficult to spot someone else's Medrol patient.

But in your own patients, you could see the advantages of Medrol right away. Why not try it?



Medrol
hits the **disease,**
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both cause and fear of
ANGINA ATTACKS

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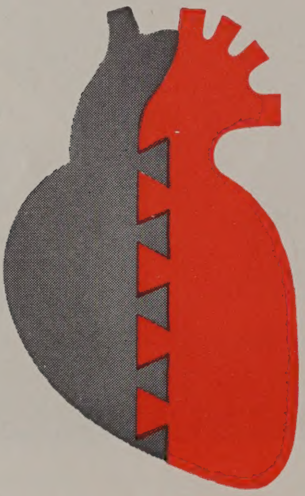

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NEW DOVETAILED THERAPY COMBINES IN ONE TABLET

prolonged relief from anxiety and tension with		sustained coronary vasodilation with
MILTOWN®	+	**PETN**
The *original* meprobamate, discovered and introduced by Wallace Laboratories		pentaerythritol tetranitrate a leading, long-acting nitrate

"In diagnosis and treatment [of cardiovascular diseases] . . . the physician must deal with both the emotional and physical components of the problem simultaneously."[1]

The addition of Miltown to PETN, as in Miltrate, "...appears to be more effective than [PETN] alone in the control of coronary insufficiency and angina pectoris."[2]

Miltrate is recommended *for prevention* of angina attacks, *not for relief* of acute attacks.

Supplied: Bottles of 50 tablets.
Each tablet contains: 200 mg. Miltown + 10 mg. pentaerythritol tetranitrate.
Usual dosage: 1 or 2 tablets q.i.d. *before meals* and at bedtime.
Dosage should be individualized.

For clinical supply and literature, write Dept. 18F

[1] *Friedlander, H. S.: The role of ataraxics in cardiology. Am. J. Card.* **1**:*395, March 1958.*
[2] *Shapiro, S.: Observations on the use of meprobamate in cardiovascular disorders. Angiology* **8**:*504, Dec. 1957.*

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STOPS COUGH TOO

The *cough control* provided by homarylamine (a non-narcotic antitussive) approximates that of codeine.

Three antibiotics (bacitracin, tyrothricin, neomycin) act in combination against a wide variety of pathogens—with little danger of side reactions.

The anesthetic-analgesic effect of benzocaine brings *soothing relief* to inflamed tissues of mouth and throat.

PENTAZETS now extend the therapeutic usefulness of convenient troche medication. Each pleasant-tasting PENTAZETS troche acts promptly against the most bothersome aspects of mouth and throat irritations.

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Dosage: **Three to 5 troches daily for 3 to 5 days.**
Supplied: **In vials of 12.**
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In potentially-serious infections...

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RAND OF TETRACYCLINE
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RAND OF CRYSTALLINE NOVOBIOCIN SODIUM

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Make new

Panalba*

(Panmycin† Phosphate plus Albamycin)**

your broad-spectrum antibiotic of first resort

effective against more than 30 common pathogens, even including resistant staphylococci.

Available forms:

1. Panalba Capsules, bottles of 16 and 100 capsules. Each capsule contains:

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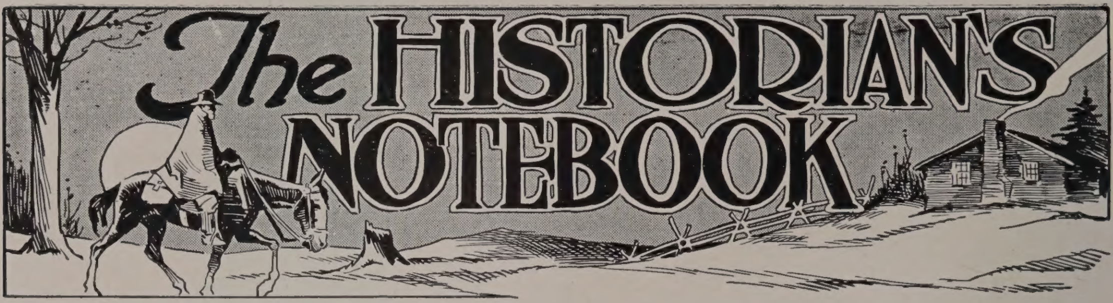

Medical Education One Hundred Years Ago — The Introductory Lecture*

GENEVIEVE MILLER, Ph. D.

PART I

EVERY historical moment has unsolved problems, and while we today may feel that we are unduly burdened and may look back with nostalgia to a more serene golden age in the past, our illusions vanish when we confront the actual situation then. Narrowing our field of vision to a tiny fragment of American medical life in the middle of the 19th century here in the Middle West, let us examine the contemporary climate of opinion, the ideals which educators upheld, the evils with which they contended. For this purpose I have consulted a number of "Introductory Lectures" given at the beginning of the school term by professors of medical colleges in this area in the 1840's and 1850's.[1]

Plan of Medical Education

Let us recall briefly the general plan of medical education at that time. After his preliminary education was finished, the teen-age boy "read" medicine for several years in the office of a local practitioner who contracted to supervise his studies and to let him observe his practice. When the student left his preceptor, he could either be examined and licensed to practice by the local medical society, or he could continue his training at a medical college whose diploma conferred upon him the title of Doctor of Medicine and the right to practice without further examination.

The medical college term began the first week in November and continued for 16 weeks, with lectures five to six hours a day. The cost of tuition was about $50.00, or $10.00 a course; board and room could be obtained for $1.50 to $2.00 per week. Two years of attendance, a $20.00 fee, and a short thesis were required for graduation; a third year of study tuition-free was recommended. The same courses were repeated each year. After the school closed at the end of February the students were at liberty to continue their studies privately, to take a job to earn money to pay the next year's tuition, or if they were already in practice to resume their professional duties.

The Author

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The "Introductory Lecture"

At the beginning of each school year a convocation was held during which an "Introductory Lecture" was given by one of the professors. Although intended principally for student edification, they frequently were open to the public in order to maintain good relations, as the local citizens usually gave financial support to the school, recognizing that it added luster and wealth to their town to have educational institutions in their midst.[2]

After the lecture it was customary for the students to appoint a committee to ask the lecturer for a copy of his address to be used for publication, and nearly all the published lectures contain the official letters between the professor and students wherein the transaction was concluded in the most laudatory fashion. For example, Prof. J.

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*Presented at the annual meeting of the Ohio Academy of Medical History, Cincinnati, April 26, 1958.

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C. Hughes of the College of Physicians and Surgeons of the Iowa University stated in his letter: "Embarrassed by the flattering terms in which you are pleased to speak of the address, and assured that its merits are not equal to the encomiums bestowed, yet desirous to gratify the wishes of the Class, for whose character and talents I entertain the highest esteem and regard, I herewith place the manuscript in your hands, to be disposed of as you may desire."[3]

The subjects discussed were entirely miscellaneous in character, although they generally contained some advice for the students in the conduct of their studies and professional careers afterwards, Usually labelled simply "Introductory Lecture," some had titles like "Homoeopathy," "On the Progress of the Science of Medicine," "Scientific Research," "The Basis Element," "Trials and Rewards of the Medical Profession," or finally the address "Strictures on Some of the Defects and Infirmities of Intellectual and Moral Character, in Students of Medicine" which Daniel Drake delivered in the University of Louisville on November 1, 1847. Eulogies of deceased professors were frequently included, and if a school had just been created, or had moved its location, this might be justified. One assumes that the expense of printing the lectures was borne by the medical college and that they were distributed for the sake of publicity.

Contemporary Problems

What were the contemporary problems which emerge from these lectures? Yes, there were financial difficulties then too, but they revolved around the simple matters of providing an adequate school building and demonstration equipment, for medical science had not yet revolutionized medical education and made the subject enormously complicated as well as expensive. In fact the acknowledged uncertainty of medical knowledge in the 1840's and 1850's was perhaps the greatest problem, for it made the profession especially vulnerable to quacks, faddists, and systematists like the proponents of homoeopathy, hydropathy, or botanic medicine.

Lecture after lecture mentioned the lack of confidence which the public had in orthodox medicine. Dr. John Butterfield, addressing the opening session of Willoughby Medical College in Columbus in 1847, said: "I know it has become much the fashion of late years, and this by men and women high in the literary world, to decry the Medical Profession, as unstable and unsatisfactory, and its practitioners as selfish, bigoted, and unworthy of confidence." Replying to lay critics of the conservative skepticism of physicians when confronted with new theories, Butterfield asserted, "We can prove Homoeopathy by a learned clergyman, and Hydropathy by an eminent novelist; and if you are not convinced of the truth of both, we can add to the former a skillful sea captain, and to the latter a distinguished female writer upon domestic cookery."[4]

"Need we be surprised," stated Dr. H. H. Childs at Willoughby in 1844, "that intelligent men extend to the profession a hesitating and doubtful confidence, when educated physicians differ so widely among themselves, avowing the most opposite views, both in theory and practice. . . . That 'Doctors disagree,' has passed into a proverb."[5]

These were the dark moments before the dawn of modern scientific medicine in European research laboratories. The physical sciences had already developed to the point where they were being applied for the increase of man's comfort and prosperity. The gas light, the telegraph, and photography had recently been introduced,[6] but the study of living nature, and more particularly of human biology was still retarded. We understand today why this was inevitable, since laboratory research in physiology, histology, and microbiology had to be developed, and knowledge of chemistry and physics had to reach a certain level before these sciences could be employed fruitfully in studying biological problems, but a hundred years ago people were impatient for answers. The sick seeking relief from pain were ready to believe any good salesman.

Weakness of Orthodox Medicine

The medical profession still had little insight into the requirements for advances in medical science, and the proposed measures were weak and ineffectual. While urging that unorthodox medical dogmas and systems be rejected, they had nothing to substitute but vague ideas about careful observation and the collection of facts as the true path to discovery. The method of careful clinical observation, which had been developed at Paris and which exerted the chief influence on American medical thought during this period, while useful for differential diagnosis of various diseases, was unable to penetrate the mystery of their cause.

Childs, for example, stated that the true method of advancing and acquiring medical knowledge is to collect facts, to apply the inductive philosophy, and to establish general principles, which was an echo of Elisha Bartlett's *Essay of the Philosophy of Medical Science* published that same year.[7] But he then proceeded to elaborate a theoretical cause of disease — debility, arising either from a deficiency of stimulus or its excessive

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application—which was as much a hypothetical system as any which he castigated.[8]

Those urging the establishment of general principles were constantly having to admit how little they knew.[9] In 1846 Dr. Abner H. Brown of Willoughby told the members of the Rush Medical Society that "it is a question by no means readily answered, whether the views [on materia medica] which generally prevail among medical men are not as incorrect and indistinct as those entertained by the people. Take up any of the ordinary works on Therapeutics, or Materia Medica: how various and contradictory are the opinions given in regard to the value and action of remedial agents. How rapidly have the hundreds of 'specifics', falsely so called, succeeded each other. How little is actually *known* of the *modus operandi* of the most common articles. A new *fact* in Therapeutics, a fact well defined and well established, is a curiosity."[10]

At this time when medicine was deficient in proved scientific knowledge, the general American attitude towards theoretical knowledge weakened it further. Americans were preeminently practical in outlook, and many practitioners thought it was essential only to have information which was directly applicable in medical practice. "In no other country, does this instinct exist in so high a degree as our own," declared Daniel Drake. "So far from being limited to the medical profession, it is an American trait, and it shows itself in all the pursuits of life—in agriculture, the mechanic and fine arts, engineering, commerce, and legislation."[11] This attitude not only resulted in empiricism in practice but discouraged studies in pure science. Practical America was not fertile soil for laboratory research in physiology as pioneered unsuccessfully by the experimentalist Charles Edward Brown-Séquard in the 1850's.[12]

(To be Concluded in January Issue)

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Data Are Being Compiled on Physicians Who Practiced in Holmes County

The Holmes County Historical Society has undertaken the project of publishing a list of the physicians that have practiced medicine in Holmes County from 1825 to 1958. The basic step in the compiling of a list of physicians of the county was made by Dr. A. T. Cole, who read a paper on this topic at a recent meeting of the historical society.

The society would like to have as complete a list as possible and so is appealing to the older residents of the county to send in information about the physicians of the period from 1825 to 1925.

The society would like to know the date and place of birth; the location and period of practices of medicine; where they went if they left the county; dates of deaths and any other outstanding activities of any of these physicians.

Anyone having information is asked to send it to Mrs. Mary Kline, at the Selective Service office, or to Co. Supt. D. C. Egger, Courthouse, Millersburg.—*Holmes County Farmer - Hub.*

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CHARLES S. NELSON,
Managing Editor — Bus. Mgr.

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Asst. Managing Editor

Complications of Endotracheal Anesthesia

GEORGE F. PARKER, M. D.

WHILE the advantages of endotracheal anesthesia are well known, the mechanisms of intubation are often difficult. It is for this reason that the disadvantages must be emphasized and re-emphasized to keep the anesthesiologist and surgeon from being lulled into a false sense of security.[14] The complications, however rare, which may accompany this technique should never be underestimated.[1] Even with the newer developments in anesthesia technique, equipment and drugs, the act of exposing the larynx and passing the tube can be the most dangerous and critical phase of the entire surgical and anesthetic procedure.

Intubation of the trachea should be available to any patient who may benefit from it; however this form of anesthesia should not be used without justification. Intubation for the convenience of the anesthesiologist rather than for the good of the patient certainly is to be discouraged.

It is true that complications and sequellae occur more commonly during the anesthesiologist's training period and become less frequent as skill develops. Yet, even the most skilled will experience an occassional unintentional complication in the induction phase of the anesthetic, during or after extubation, and in the immediate or late postoperative period. Aside from the major or minor injuries inflicted upon the patient, it is not inconceivable that embarrassing medico-legal entanglements may ensue as a result of intubation mishaps.[21]

A modest survey of the literature reveals many isolated case reports of both common and bizarre complications which have occurred during laryngoscopy and passing of the tube. There are a few small series of cases presenting a limited amount of data on the post-traumatic sequelae of endotracheal intubation. In general there are no recent extensive studies which would indicate a statistical account of the prevalence of the various endotracheal complications which are apt to confront the anesthesiologist in his everyday practice.

The Author

● Dr. Parker, Springfield, is Director of the Department of Anesthesiology, Mercy Hospital.

The difficulties which may be encountered during endotracheal anesthesia may be classified as:

A. Those traumatic episodes which occur immediately.
B. Technical and physiological complications, including undesirable reflex phenomena as well as ventilatory problems.
C. Postoperative complications and late sequelae, some of which are diagnosed and treated by our otolaryngologist conferees, who thereby gain an unfavorable impression toward endotracheal anesthesia in general.

Although there is considerable overlapping in this classification, the complications can be briefly considered in a more or less orderly sequence.

A. Immediate Complications

1. Lacerated or bruised lips and gums.

2. Dental avulsion, loosened, cracked and chipped teeth. (Mostly caused by using the upper

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From the Department of Anesthesiology, Mercy Hospital, Springfield, Ohio.

Read before the Joint Session of the Sections on Anesthesiology and Otorhinolaryngology of the Ohio State Medical Association Annual Meeting, Cincinnati, April 15, 1958.

incisors as a fulcrum for the blade of the laryngoscope.)

3. Contusions or hemorrhage in the pharyngeal mucous membrane or in the region of the ascending mandible, the tonsillar pillars, the tongue base or the epiglottis. (Most frequently, the epiglottis sustains a crushing type of injury from undue upward pressure exerted by the laryngoscope.)

4. Lacerated turbinates or partial adenoidectomy as a result of forced nasal intubation. Occasionally the anesthesiologist not only may lose more blood than the surgeon, but also creates a disturbing hemorrhagic problem which may make any intubation approach far from ideal. Epistaxis can be minimized by adequate lubrication of the tube and by careful technique of passing the endotracheal tube straight back along the floor of the nasopharynx rather than upward with undue force.[16] A comparatively soft tube is mandatory, and shrinking of the nasal mucous membrane is often desirable to assure an atraumatic passage of the tube.

5. Submucosal hemorrhage of the true and false cords.

It is evident that these immediate and largely preventable injuries are inherent in poor direct laryngoscopy, inadequate anesthesia, or both. To avoid these frustrating episodes it is necessary to develop an anesthetic technique sufficient to give adequate relaxation to the jaw and neck structures and to obtund the very sensitive laryngeal and pharyngeal reflexes.

With adequate anesthesia including relaxation the head may be properly positioned, the mouth does not have to be pried open, the tongue may be easily pushed to the left, vision will be unobstructed and the anesthesiologist will have enough time to execute both laryngoscopy and intubation atraumatically. Beecher's statement that "trauma increases directly as the skill of the anesthetist is deficient"[22] certainly draws no argument when applied to intubation technique. There is no substitute for gentleness in manipulating a laryngoscope. Poor anesthesia makes the instrument a dangerous tool whereas good anesthesia facilitates the simple use for which it is intended—the exposure of the vocal cords and the trachea.

Anatomical variations such as recession of the mandible, protruding upper incisors, increased size of the tongue or the short, thick, bullneck type of patient demand faultless anesthesia and laryngoscopy to avoid difficulties. It may be well to consider intubation under local anesthesia in the awake patient as a safer and less traumatic procedure in some of these cases.

B. Technical and Physiological Complications

1. Obstruction to the lumen of the tube. Old worn-out tubes are most apt to kink or collapse. Obstruction also occurs if a patient bites on the tube. This is almost entirely the result of failure to insert an adequate bite block.

2. Faulty position of the tube in the trachea may occlude the bevel against the tracheal wall. Insertion of the tube into the right main-stem bronchus results in inadequate ventilation since the left bronchus and the right eparterial bronchus are occluded.

3. Unrecognized esophageal intubation may lead to asphyxia as well as a dilated stomach.

4. Prolonged manipulation during a difficult intubation may subject the patient to severe anoxia. As the late Rolland Whitacre[17] has pointed out, "More than one anesthetist engaged in such a struggle has been so engrossed with this particular task that he has sighed with relief to see the endotracheal tube in place—only to discover that his patient meanwhile has died because of a simple lack of oxygen."

5. Increased resistance to respiration by tubes which are too small. Hypercapnia, hypotension and undesirable reflexes may occur in addition to the extra physical work imposed on the patient to move gases in this situation.

6. Cuffed tubes offer special technical problems in addition to those already cited.

   a. Overinflation occasionally causes the cuff to occlude the lumen of the tube. Failure to recognize this difficulty has resulted in asphyxia fatalities.[18]

   b. The cuff may slip down over the distal end of the tube resulting in immediate obstruction.[8]

   c. Soft rubber tubes may be compressed by excessive pressure.[18]

   d. One fatality from rupture of the cuff has been cited by Lennon and Rovenstine.[5] The injury incurred, the only report of its kind in medical literature, was of the blast type.

7. Laryngospasm. Laryngoscopy and intubation frequently initiate extreme degrees of laryngospasm leading to severe grades of hypoxia sometimes requiring every resource at the anesthesiologist's command to break the spasm.

Generally this group of complications involve hypoxia, hypercarbia and asphyxia, all of which may be serious in the individual patient. Catastrophes[12] are more likely to ensue from these causes rather than from the reflexes incurred by the laryngoscope or the tube itself.

Undesirable Reflex Phenomena

Transient circulatory disarrangement such as reflex hypertension, hypotension, tachycardia, bradycardia and certain cardiac arrhythmias are undeniably associated with both laryngoscopic manipulation and the pressure of the tube in the trachea. The relative importance of these circulatory responses in the anesthetized patient are not completely understood or evaluated.[12] Some are no doubt harmful particularly if prolonged or if occurring in the patient who already has a damaged cardiovascular mechanism. Certainly all undesirable reflexes should be avoided as far as possible.

King et al.[6], believe that these unwanted reflexes occur more often during light anesthesia. Denson[23] suggests that the changes in cardiac rhythm during intubation and extubation formerly ascribed to the vagovagal or tracheo-cardiac reflex is really a result of inadequate ventilation either preceding the insertion of the tube or before it is withdrawn. Whether some of these noxious reflexes are enhanced by relative hypoxia, carbon dioxide retention or both, is not clear.[19] There is also considerable doubt whether cardiac standstill can be initiated solely by the laryngoscope or intubation.[19]

Undesirable respiratory reflexes may occur secondary to the mere presence of the tube in the larynx and trachea. Laryngospasm, coughing, bucking, and bronchospasm may be precipitated by the laryngoscope or the tube which may lead to hypoxia and hypercapnia. Pre-intubation spraying of the glottis with a local anesthetic agent in addition to adequate anesthesia and a reasonable degree of skill will prevent most of these disturbing reflexes.

Paradoxically, inadequate ventilation appears to be the major dysfunction in the technical and physiological disturbances caused by endotracheal anesthesia, while the reflex phenomena assume a relatively minor role. Most of the difficulties can be prevented by good anesthesia technique, a reasonable degree of skill and the ever-present quality of alertness that every anesthesiologist should cultivate.

C. Postoperative Complications And Sequelae

1. Minor complications appearing early in the postoperative period include:

a. Rhinitis.

b. Infection in the oropharyngeal wounds caused by unskillful manipulation of the laryngoscope and tube.

c. Pharyngitis.

d. Laryngitis.

e. Tracheitis, usually caused by the tip of a stiff curved rubber endotracheal tube pressing against the anterior wall of the trachea. Unclean tubes are also a definite factor. Overinflated cuffed tubes may produce pressure necrosis on the tracheal wall.[10, 11]

The patient may complain bitterly about his sore mouth or throat, his difficulty in swallowing or his hoarseness. These complaints may even eclipse those caused by the surgical wound. Infection superimposed on mechanical trauma to soft tissue is the primary cause of these complications. Bacterial invasion may arise from organisms already present in the nasal and oropharyngeal cavities or may come from unclean equipment. To quote Robert Smith of Boston, "The anesthetist who lacerates the glottis and then rubs a dirty tube across the wound has committed a serious offense."[7]

2. Various major pulmonary complications have sometimes been attributed to intubation. Presumably, pneumonia has resulted from the passage of the tube through a grossly contaminated area (the nasopharynx in the presence of acute sinusitis, or the oropharynx in the presence of an acute pharyngitis). Routine aspiration of the trachea and bronchi before extubation and the ease with which complete expansion of the lungs can be accomplished during endotracheal anesthesia probably prevent a greater incidence of pulmonary pathology.

3. Edema of the glottis, particularly when occurring in infants and children, can produce a serious type of respiratory obstruction. Jackson[9] has emphasized the anatomical fact that the subglottic tissue of children is prone to edematous reaction because of the relatively greater proportion of loose areolar tissue in its cellular structure. Also, it is obvious that the small lumen of a child's glottis may be occluded by a minimum of swelling. Extreme care should always be exercised to avoid trauma to the larynx of a child during intubation. Failure to recognize infant laryngeal variations can lead to laryngeal trauma and edema and even to death. Postoperative tracheotomy may be lifesaving in these cases.

4. Tracheal and laryngeal edema representing an allergic response to the material incorporated in the tube or the lubricant may occasionally be encountered. The ensuing obstruction may be

severe enough, even in the adult, to necessitate tracheotomy.

5. Subglottic Membrane: In a recent paper[1] this somewhat baffling complication was recognized five times in a series of 2500 endotracheal anesthesias; a rather appreciable percentage when one considers that a tracheotomy was eventually necessary in every case. The condition occurs primarily in women and children usually 24 to 48 hours or so postanesthesia time.[13] The clinical picture is that of acute upper respiratory obstruction being ushered in by a cough, hoarseness, stridor, dyspnea and suprasternal retraction. Without immediate treatment the complications of anoxia ensue.

Mechanism

Since the subglottic area is the narrowest point of the larynx it may be easily injured during the process of intubation, either by the tip of the curved endotracheal tube or the projecting point of the introducer stylet. Prolonged pressure against the subglottic membrane by a deflated and wrinkled cuff can also produce minute superficial abrasions. Leukocytes and desquamated epithelial cells accumulate about the abraded area forming a membranous-like structure. Respiration is impeded in part by this membrane and in part by the reflex adduction of the vocal cords.

Differential Diagnosis

Etsten and Mahler[13] believe that a subglottic membrane is many times erroneously diagnosed as edema of the glottis. This error is most likely to occur if a tracheotomy is hurriedly performed without previous visualization of the larynx. Direct laryngoscopic examination reveals a normal glottic chink, epiglottis and larynx. Bronchoscopy, however, reveals the true nature of the obstruction. Bronchoscopic removal of the fibropurulent membrane is the treatment of choice. Tracheotomy is usually not necessary after complete removal of the membrane.

6. Cartilage and Perichondrial Injuries: Direct injuries involving the epiglottis, thyroid, arytenoid, and cricoid cartilages and their perichondrial covering have been recorded.[3] Dislocation of the cricoarytenoid articulations has occurred. Such mayhem is almost always the result of using brute strength instead of gentleness in the intubation procedure. Improper manipulation of metal introducers and stiff rubber or hard woven silk endotracheal tubes are also dangerous in the hands of the inept operator. Usually the site or the extent of the injury is not diagnosed until later in the postoperative period. Certainly a skilled laryngologist should be consulted if any trauma of this sort is suspected.

Laryngeal Stenosis

The healing process of the cartilages of the larynx is notoriously poor, therefore when these structures have been traumatized, perichondritis, prolonged suppuration, cartilagenous necrosis and scar tissue formation with subsequent deformity may result. Laryngeal stenosis is a late sequelae if prophylactic and remedial measures are not instituted promptly.

7. Contact Ulcer with Granuloma Formation: In contrast to the preceding group of cartilagenous injuries where severe direct trauma plays the major role, contact ulcer is usually the result of injury to the vocal process presumably caused by the presence of the tube in the glottis. This clinical entity long known to laryngoscopists was first described by Chevalier Jackson[9] in 1928 on the basis of 248 personally observed cases over a 40 year period. In none of these original cases was the laryngeal condition a sequela of endotracheal anesthesia or endolaryngeal instrumentation. Clausen[4] described the first case of laryngeal granuloma following intubation in 1932.

This nonspecific ulcer of the larynx is located on the tip of the vocal process of the arytenoid cartilages, and according to Jackson[9] may follow intubation for several reasons:

> *a.* The endotracheal tube acts as a foreign body causing a powerful clamping of the glottic closure. The tube then scrapes over the vocal processes of the arytenoids which project their thinly covered joints against the tubal surface. This mechanism occurs if the tube is introduced before laryngeal reflexes are entirely abolished or if anesthesia diminishes sufficiently to allow the reflexes to reappear.
>
> *b.* Since the tips of the vocal processes project prominently into the lumen of the glottis, they may be hooked by the slanted open end of the tube.
>
> *c.* Light anesthesia may not abolish the autonomic movements of the artenoids and they continue to rub the tips of the vocal processes against the surface of the tube.

This latter physiological rubbing mechanism is probably the most frequent cause of indirect trauma resulting in contact ulcer granuloma associated with endotracheal anesthesia. One or both arytenoid cartilages may be involved. Since the reparative power of laryngeal cartilage and perichondrium are extremely poor, flabby granulations tend to form. The healing process is especially frustrated by continued vocal abuse.

To prevent this complication, the anesthesiologist of course must avoid any gross trauma to the vocal processes. Jackson[9] has emphasized that the use of clean, well lubricated tubes as well as relatively soft and absolutely smooth tubes will minimize the incidence of contact ulcer.

Tubes should be examined before each anticipated intubation and those with the slightest imperfection on the smooth glass-mold surface should be considered unfit for use in the larynx.

Diagnosis

Early diagnosis of injury to the vocal process requires that every patient who has any complaint referable to the larynx in the postoperative period should have at least a mirror laryngoscopy. Some anesthesiologists may be competent in this branch of otolaryngology, but most of us need the help of an experienced laryngologist to appraise whatever pathology may be present. This seems to be the only rational way to detect this unfortunate complication early enough to prevent the serious sequela of a permanently impaired voice, or at its worst, varying degrees of laryngeal obstruction.

With proper treatment contact ulcer and contact ulcer granuloma are curable in practically 100 per cent of the cases. When treatment is not delayed the voice is usually good.

8. Several isolated reports[2] of paralysis and laceration of the vocal cords, perforation of the pyriform sinuses[15] and trachea have appeared in the literature. Permanent voice alterations, secondary mediastinitis and fatalities may be associated with such injuries.

Other than poor intubation and/or anesthesia technique, some occult anatomical deformity or the presence of an unrecognized pathological process, it is difficult to explain some of these rare and bizarre complications. It may safely be stated that most of these accidents are probably preventable.

Summary and Conclusions

Many of the common and less common complications of endotracheal anesthesia have been presented. Various aspects of their etiology and potential causes have been discussed. The opinion is expressed that endotracheal anesthesia should not be used indiscriminantly and that false pride should never deter an anesthesiologist from seeking the aid of a qualified laryngologist to determine the extent of any injuries which may have been inadvertently caused by an anesthesia practice so vitally important to modern surgery as endotracheal intubation.

If the anesthesiologist will produce adequate anesthesia and relaxation for intubation, if he will develop and use the skill and gentleness of the bronchoscopist, and if he will take meticulous care of his endotracheal equipment, both minor and major complications of endotracheal anesthesia will be practically eliminated.

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Primary Diaphragmatic Tumors

Whenever routine chest x-ray reveals an abnormality of diaphragmatic contour, tumor of the diaphragm should be considered. Radiographic examination of the barium-filled stomach should be done if disease of the left leaf of the diaphragm is suspected. Diagnostic pneumoperitoneum then may be employed to confirm the suspicion of tumor. A certain number of diaphragmatic tumors can only be proved by exploratory thoracotomy.—Charles E. Littlehales, M. D., Portland, Ore.: *Northwest Med.,* 57:1309, October, 1958.

Prognosis and Pathogenesis of Acute Glomerulonephritis In Adults — A Review, with a Case Report

DAVID H. GREEGOR, M.D.

COMPLETE recovery from acute diffuse glomerulonephritis is certainly not a medical rarity—in fact, in even the most pessimistic statistical reports it happens in approximately one half of the cases. However, we recently had the privilege of witnessing one such recovery from a very severe acute attack that was definitely unusual and perhaps even remarkable in that the patient underwent a nephrectomy in the first weeks of her illness.

Case Report

The patient, a 30 year old white female, entered the hospital because of nausea, vomiting, convulsions and anuria. Two months prior to admission she had entered another hospital to determine the cause of recurrent attacks of chills, bloody urine and painful urination. During this first hospital admission there had been no elevation of temperature; blood pressure ranged from 120/80 to 140/100 and intravenous pyelography demonstrated a stone in the pelvis of the right kidney associated with questionable blunting of the calyces. After careful study by both medical and urological services she was considered to have chronic, unilateral pyelonephritis and released to her home for two weeks' trial therapy on a sulfonamide preparation.

Two weeks later she re-entered the same hospital showing no evidence of improvement. A right nephrectomy was performed and the initial pathologic report was acute pyelonephritis with stone. At a later date all specimens were subjected to re-study and final diagnosis was severe acute diffuse glomerulonephritis. Her postoperative course was marked by some vomiting, grossly bloody urine associated with normal menstruation and progressive anemia requiring a number of blood transfusions. Seven to 10 days postoperative her general condition and red blood count were considered satisfactory enough to release her to her home under the care of her family physician.

During her two weeks at home the vomiting increased, urine output decreased, patient became weaker and urine remained grossly bloody. Three days prior to admission she was oliguric and unable to retain even water by mouth. On the day of admission she had two generalized convulsions and was brought to a second hospital.

Physical examination revealed a pale young white female, acutely ill, and semicomatose. Temperature and respiration were normal. Blood pressure 160/100, pulse 112, eye grounds and ears, nose, and throat not remarkable. No palpable thyroid abnormality and no lymphadenopathy. Chest was clear. Heart did not appear enlarged to palpation and the only auscultatory abnormality was a grade II systolic murmur at mid-precordium. There was a recent nephrectomy scar in satisfactory state of healing. No palpable abnormalities of the abdomen. There was profuse vaginal bleeding and gynecologic consultation indicated that there were no pelvic abnormalities or pregnancy. Extremities and reflexes showed no significant changes.

Laboratory reported nonprotein nitrogen 141 mg. per 100 ml., hemoglobin 10.9 grams, red blood cell count 2,940,000, white blood cells 19,450 with 86 per cent polymorphonuclear leukocytes, hematocrit 31 per cent, blood sugar 140 mg. per 100 ml., sodium 136 mEq/L. Potassium 4.6 mEq/L, chlorides 87 mEq/L. Coagulation time was seven minutes, bleeding time three minutes, platelets 282,240. Urine cultures grew E. coli, nonhemolytic Streptococcus and hemolytic Staphylococcus aureus coagulase positive.

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It was felt at the onset that part of the oliguria could be explained on a dehydration basis resulting from protracted vomiting and decreased fluid intake. The patient was given 5 per cent glucose in water both intravenously and subcutaneously with all members of the attending staff watching carefully for signs of cardiac embarrassment. The first day patient received a total of 1500 cc. Terramycin® was included in the intravenous administration. Four cubic centimeters of 50 per cent magnesium sulfate was given intravenously on two occasions to control the convulsions and mounting blood pressure. Sodium Luminal® was administered intramuscularly.

The second day the patient's condition was much worse. She was in coma and could not always be aroused. Major seizures were frequent. Only hopeful sign was that she began to put out urine and the second day's output was 1000 cc. Urine was grossly bloody, alkaline, specific gravity 1,016, albumin 350 mg. per 100 ml., and microscopic analysis revealed an occasional granular cast in addition to the many red blood cells. Patient was given Bonadoxine,® Terramycin intravenously, magnesium sulfate intravenously, 1 unit of blood and 1500 cc. of saline-free fluids subcutaneously.

The following day her condition remained the same. Eye grounds showed no remarkable changes although there was some blurring of the left disc margin. Vision was blurred. The systolic heart murmur heard at the left sternal border, mid-precordial region, developed a more intense blowing quality and perhaps signified some cardiac dilatation. Nonprotein nitrogen was 152 mg. per 100 ml., CO_2 combining power 26.7 mEq/L and patient still convulsed at intervals. Total fluid administration was calculated on the basis of previous day's output and patient was given 2000 cc. of 5 per cent glucose in water subcutaneously.

Fourth hospital day condition was generally worse. There was some facial edema, potassium 3.7 mEq/L, blood pressure 170/118 and mental confusion. However convulsions decreased in number and renal output remained at a satisfactory level of 1000 to 1500 cc. One thousand cubic centimeters of saline-free fluid was administered.

Fifth hospital day produced dramatic improvement—patient could take fluids by mouth and there was definite clearing of the sensorium. From that day on improvement was steady and patient was discharged to her home and bed rest on the thirteenth hospital day. At that time blood pressure was 124/80. Last nonprotein nitrogen in the hospital was on the tenth day and reported 102 mg.

Since her discharge patient has been followed carefully and to date shows no signs of any residual renal lesion. Blood urea nitrogen and blood pressure are normal; urine has remained free of albumin and the miscroscopic analysis is clear.

Incidence and Prognosis

Glomerulonephritis is not an uncommon disease but as a cause of death it is listed as less than one half of one per cent. However students and observers differ widely in their estimates of the chances for complete recovery from the acute attack (without entering any segment of the chronic phase). Bright in his original papers in 1827 was very pessimistic but as his experience broadened he became less so. In 1877 Bartels pointed out that many patients were getting along very well with the disease in an arrested state.

Kieth[1], in attempting to formulate some idea as to prognosis in all stages of the disease studied 50 of his own cases which he had closely observed for over 30 years at the Mayo Clinic. He found that, (1) All eight of his acute cases had completely recovered. (2) Four of the chronic cases did the impossible and completely recovered. (3) Some patients took from five to eight years before recovering from the acute attack (latent phase). Many other writers have rather glowing statistics; Sussman,[2] for instance, states that 90 to 95 per cent of the acute cases will completely recover and only two (5 per cent) will develop chronic disease.

Most of the reports[3] however, indicate that less than 50 per cent of the adult cases will completely recover. Murphy[4] followed 205 cases over a period of 2 to 10 years. Only 41 per cent were completely cured at the end of the acute stage. Nine (2 per cent) remained in the latent stage which is characterized by lack of symptoms and findings indicating renal disease except for the presence of significant quantities in the urine of red cells and albumin. There were 12.6 per cent who died in the acute stage and 26.8 per cent entered the chronic stage.

Murphy[4] and others in commenting upon the wide divergency between published recovery statistics explained the more optimistic reports as follows: (1) Although some workers deny it, the recovery rate is definitely better in children and many of the high recovery groups are comprised in the main of pediatric cases. (2) Many observers have failed to recognize the patients in the latent phase. After World War I it was possible to follow large numbers of adult cases and both European and American reports corroborate the 45 per cent (complete) recovery rate.[4]

Accuracy of Statistics

Is the situation actually this bad—is it possible that the acute adult patient has no better than a 50 per cent chance for complete recovery? It is this writer's opinion that the picture is more promising than indicated. Most of the statistics include a large number of patients who first came under medical observation in the chronic stage and who were completely unable to give any history of the acute attack. This has caused a few physicians to consider acute glomerulonephritis and chronic glomerulonephritis as distinct and separate diseases and not as stages of the same illness. This conclusion is not shared by the profession at large but it does indicate that a significant number of people go through an unrecognized acute stage into chronic renal damage.

By the same reasoning it is only fair to conclude that there must be many unrecognized acute cases which clear completely and which are never accounted for in medical statistics. If we couple this deduction with the fact that most case studies where the cases were observed from the initial stage give high recovery rates, we have the right to expect a much better than 50 per cent rate for our acute cases.

Certain questions immediately pose themselves: (1) What factors actually determine complete recovery? (2) Does it depend entirely upon the violence of the antigen—antibody reaction? (3) Or does it depend primarily upon early diagnosis and adequate medical care? (4) Is there any way in which we can predict the eventual outcome for a given case?

Murphy[6] attempted to answer some of these questions in his study of 30 cases selected from all stages of glomerulonephritis. He concluded that, (1) acute respiratory infections played no part in ultimate course; (2) proteinuria was always present but not a finding upon which to base prognosis; (3) cardiac complications were frequent (70 per cent in overall study) but not the chief cause of death and therefore not a principal factor in prognosis; (4) the most practical index to prognosis was the degree and behavior of the diastolic blood pressure. The cases ultimately demonstrating the most renal damage usually showed significant and progressive diatolic hypertension.

Etiology and Pathogenesis

The studies of Rammelkamp[15] and others incriminating members of group A, beta hemolytic streptococcus have been generally accepted. These studies indicate that only certain strains of the group A are capable of producing glomerulonephritis. To date these strains are type 12 (the most common), type 4, Red Lake[14], and some of type 25.

The medical profession has been very fortunate in its study of glomerulonephritis to have the benefit of many laboratory experiments in which it was possible by immunologic methods to reproduce the disease in dogs, rats and rabbits.[7, 8, 9, 10, 11, 12, 13]

Animal Experimentation

Mellors et al.[11] used fluorescein labeled antisera in rabbits and demonstrated that those animals developing nephritis have a concentration of the antibodies in the glomerulus, particularly in the basement membrane. They concluded as did Seegal[17] from his work in dogs and rats, that the basement membrane must be the source of the antigen which incites the production of the nephrotoxic antibodies. Perhaps it should be pointed out at this time that all investigators are agreed that there is no actual bacterial invasion of the kidney which is responsible for acute glomerulonephritis but that the disease is a direct result of a hypersensitivity reaction[8] taking place among other sites, in the glomerulus.

In further rabbit experimentation the Mellors group[12] injected 15 rabbits with bovine gamma globulin and used their same micro-technical approach. Twelve of the rabbits developed glomerulonephritis and the antibodies were again found in the glomeruli—presumably localized there by the fixation at that site of the injected antigen. In human cases[16] where gamma globulin was used prior to the onset of nephritis, studies of the serum complement suggested that the pathogenesis was, as in the animal studies, an antigen-antibody reaction. Data derived from cases of nephroses and chronic glomerulonephritis has been less convincing along this line indicating there are probably additional pathogenetic mechanisms at work in the development of the chronic state of renal disease.

Other illuminating reports on animal experimentation include that of Bevans et al.[10] that dogs progressing into the chronic stage showed no fresh exudative lesions along the way indicating that the initial insult determined the course because there was no continuous or repeated injury. However the statistics of Murphy and Peters[4] in human cases indicates that prognosis is not affected by the fact that the acute phase is stormy or mild. The importance of pregnancy in the disease has remained controversial—pregnant rats developing nephritis from antiplacental serum would abort whereas dogs neither aborted nor developed the toxemia syndrome.[9]

In animals cortisone inhibited the development of nephritis[8] and perhaps it would do the same in human beings if we only had the advantage of being able to use it before the renal lesions are formed.

Hamilton and Fremes[13] found the dividing line between recovery and progression into the chronic stage to depend upon the state of continuity and integrity of the capillary basement membrane following the initial insult. If this were seriously disrupted the proliferating epithelium of Bowmans[1] capsule laid down collagen with ultimate periglomerular fibrosis obliterating the glomeruli. If the basement membrane remained intact resolution eventually took place.

Attempting to apply Hamilton's conclusions to the case reported in this paper we reviewed the microscopic sections of the removed kidney and noted that although there was widespread glomerular swelling there was little if any destruction of the basement membrane and in general the glomerular architecture was well preserved. Perhaps from this evidence we might have predicted that should the patient be able to survive the violence of the acute attack that complete resolution of the kidney lesions would take place.

Treatment

It is not the intent of this paper to discuss treatment in detail but some comments on relative importance of the various parts of the medical program are in order. The essentials of management during the acute phase are as follows:

(1) **Diet**

(a) Salt should be restricted to 0.5 gram or less per 24 hours.

(b) Protein content may be normal unless azotemia is marked in which case there would be some restriction. Hypoproteinemia would, of course, call for additional amounts of protein.

(2) **Strict bed rest.**

(3) **Intravenous infusions** slowly and only upon definite indication such as dehydration from vomiting, inability to take oral fluids, etc.

(4) **Intravenous magnesium sulfate** to control convulsions and other effects of hypertensive encephalopathy.

(5) **Management of cardiac failure** when present.

(6) **Treatment of specific infections** when present with a special search for the presence of beta hemolytic streptococcal infections.

Among those suggested therapeutic weapons which are of little or no value are cortisone and the artificial kidney. Usually any patient with acute glomerulonephritis to the extent that he is anuric for several days has so much widespread glomerular obliteration that the artificial kidney can do little but delay the eventual demise.

Kieth[1] in his series felt that salt elimination played the most important part in the whole treatment program. Schnechloth and Page[3] have also pointed out that the major part of their program is built around bed rest and salt restriction. The Murphy and Peters[4] report emphasizes that good results can only be obtained by a close watch over the patient during the latent phase following the acute stage and the use of strict bed rest during this period if any signs of an exacerbation appears.

And finally—a word on prophylaxis: a very widespread epidemic of acute glomerulonephritis took place on the Red Lake Indian reservation[14] in northern Minnesota in the summer and fall of 1953. Cultures grew an untypable strain of group A, beta hemolytic streptococcus. The epidemic was aborted within two weeks by mass prophylaxis with benzathine penicillin; 600,000 units to small children and 1,200,000 units to the older patients.

Summary

It has been pointed out through clinical experience, animal and human experimentation that the following factors influence the prognosis for complete cure in adults suffering from acute diffuse glomerulonephritis.

(1) Proper medical management in which salt restriction is one of the most important features.

(2) Age.

(3) Presence or absence (and degree) of diastolic hypertension.

(4) Complications.

(5) Total effect upon the glomerulus (basement membrane in particular) by the initial hypersensitivity reaction.

(6) Close observation of the patient during the latent phase following the more stormy acute stage.

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Tranquilizing Drugs And Their Misuse

. . . This leads me to discussion of the misuse of tranquilizing drugs in trying to help our patients achieve peace of mind. The casual use of these products for the relief of everyday tensions is not sound medical practice. Granted that many of the drugs are relatively safe, still such use of them does not seem to me to be wise. If we allow such a practice to spread, we can picture our society becoming a very dull one, composed of "tranquilized" people without emotions. There is reason to believe that a certain amount of anxiety, tension, or fear may be necessary stimulants to the finest attainments of man. If we merely tranquilize our patients, we may lull them into a state of pseudo-health and actually we may weaken their adaptive capacities. I have seen many patients who received tranquilizers without relief. They have come for psychiatric help with a hopeless feeling, thinking that if the drugs didn't help, nothing will. It is deplorable to stimulate false hope by promising relief that perhaps can't be delivered.

In order to adapt successfully, one must take thought. One must attempt to know one's self; this is the only way that a person achieves lasting peace of mind. It has been my experience that most patients want this kind of help from their physicians; they don't want to be merely "tranquilized." They are looking for genuine happiness, not just relief of symptoms with medicine. An understanding relationship between the patient and his doctor is still the basis of effective medical practice. This relationship allows the physician to explore the reasons behind a patient's complaints. In such a situation there is no prescribing until a full evaluation of the patient is made; an attempt is made to understand the patient's personality and emotional needs as well as his physical and laboratory status.—Ralph Burbridge, M. D., Erie, Pa.: *Pennsylvania M. J.*, 61: 999, August, 1958.

Medical Research and Medical Practice in Industry

ROBERT A. KEHOE, M.D.

Introduction

WHEREAS in most fields of medical practice, the physician practices, or carries out research, but rarely does both, in industrial medical practice one does both constantly or must be in readiness to do both at all times. It can be said, of course, that every patient in every doctor's practice presents a problem to be investigated, and in this sense all medical practice is research. Such investigations in private practice usually end with the solution, or near solution, or the recognition of failure to achieve a solution, of the problem of a specific patient. In contrast, in the practice of industrial medicine, the patient is often merely the means of opening an avenue of investigation which, having been begun, persists and finds its solution, if any, far beyond the handling of the patient, however satisfactory that may be.

It is recognized that the difference referred to in the two types of practice is one of degree, and that the main divergence of the two lies in the fact that most of the problems of private practice have been with us for a long time and have been illuminated by the work of a host of physicians and investigators. Many problems of industrial medicine, on the other hand, have come upon us fairly recently, and new ones are being created daily, while only a minute proportion of the resources of medicine, up to the present time, has been directed toward research in industrial medicine.

But to return to the initial differentiation, the fact is that research is and must be at the fingertips and in the mind of every industrial physician who understands his job. Indeed, the practice of industrial medicine in our day is research, or so it must become if we are to achieve any significant part of the task that lies before medicine in industry. This fact arises from the nature of the tasks and the methods of research in industrial medicine, and this — the nature of such research — is the main subject of this discussion.

Before entering upon the main discussion, however, it is of some importance to recognize another horn of the industrial doctor's dilemma. It is not enough that he must be both practitioner and investigator, with knowledge of methodology, and skill in its application. He must, in addition, whenever the opportunity presents itself to him as a practitioner of industrial hygiene, be prepared to eliminate the very conditions about to be investigated. Since these conditions have been created by man and not by nature, they can be both understood at once, from the aspect of their origin, and changed almost over night.

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It often happens that preventive measures remove important factors in the production of disease, modify others, obfuscate etiologic and epidemiologic factors, and wipe out, utterly, the clinical material without which a disease entity cannot be observed and described. Thus the substitution of one material for another eliminates a problem, although it may merely postpone its initiation and investigation, and, perhaps, may allow it to arise later under conditions in which the need for research will not be recognized, or in which the capability for research is lacking.

The same result, with respect to the elimination of one aspect of medical research, is achieved when methods of environmental control, devised and implemented jointly by the engineer and the doctor in industry, reduce occupational exposure to materials or sources of energy, and keep it within harmless limits. In the latter situation, however, research will have been employed, usually, to establish standards of safety, and much will have been learned, and one hopes, much of what has been learned will have been made available generally.

The Nature of Research in Industrial Medicine

For many physicians the term research has a formidable and forbidding aspect, as being an

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From The Kettering Laboratory in the Department of Preventive Medicine and Industrial Health, The University of Cincinnati College of Medicine.

Read before the Section on Industrial Medicine at the Annual Meeting of the Ohio State Medical Association in Cincinnati, April 15, 1958.

affair of a place apart, an assembly of ideas and techniques far beyond, or at least unfamiliar to, the man of practical mind and hand. If it is not formidable in the sense of being beyond one's understanding and competence, it is forbidding as being impractical, visionary, fundamental in the sense of lacking utility, and pure through being insulated by clinging ivy from all vulgar contact with reality.

With the advent of applied research on the grand modern scale, especially within industry, the concept of research as a sacrament of science, so to speak, has receded, but the fetish of complex instrumentation remains to clothe this field of endeavor with the aura of the unfamiliar in human capacity and performance. This investiture of research with highly specialized qualities is unfortunate, not only in its effects upon its devotees, but upon those who view it from afar, and precisely because it is viewed from afar.

Good research is based primarily upon sound thought—the imaginative and industrious search for evidence, and the examination of evidence critically and systematically. It involves the use of the tools of modern science, which, in essence, represent extensions of the capacity, sensitivity and accuracy of man's special senses. But when, as is often the case, the manipulation of the tools is substituted for the intellectual process, the result is unintelligible, being only contributory to a wider and deeper chaos for being outside the realm of sound intellectual appreciation and critique.

Whether one has in mind, as tools, the automatic machinery for recording observations, the electronic computation of results, or the application of the mathematical formulae and equations of biometry, the problem is the same, in that the instruments cannot penetrate beyond the intellectual vision of their operator. They introduce precision into observation, they provide us with strength and endurance far beyond our capacities, and they increase our speed of performance manyfold, but they do not solve our primary problem. It is still necessary for the investigator to determine what it is that he wishes to know, to postulate where the answer lies, and to plan his strategy in such a manner as to test rigidly the truth or falsity of his postulation.

It is in this atmosphere of sound and often simple logic that we take a look at research in industrial medicine. Considering its urgency, we lay upon it one other requirement, that it give us answers, as quickly as possible—final answers, if possible, but partial answers, if need be—which we can use in our day's work. Industrial medical research is applied research, *ad hoc* research, if you please, contract research, if it must be, but in any case utilitarian research, which will hold at bay, for the time, until we can do more and better, the threats to human life and health—physical and mental—which lurk, often unsuspected, in almost every technological achievement of our time that finds its way into industrial production and service.

FIELDS OF INDUSTRIAL MEDICAL RESEARCH

Industrial Toxicology

The field of research which comes first into the mind of most industrial physicians, especially those associated with industries in which chemicals are manufactured or handled, or in which the processes employed tend to disperse into the air gases, vapors, fumes, mists or dusts, is known as industrial toxicology.

Whether one is concerned with a new substance or one that is well known but has been insufficiently explored or has presented itself in a new guise or a new situation, the problems at issue in relation to industrial health and hygiene are much the same in principle. The questions that arise, in relation to potential or overt industrial hazard, are the following:

(a) How is this material, in its relevant form or forms, absorbed into the human body?

(b) What are the symptomatic responses, if any, of human beings, to its absorption, and what are the pathologic effects, chemical or anatomical, which induce such responses?

(c) What quantities of the material must be absorbed into the human body to induce toxic effects, and what are the relative rates of absorption into the body by way of the various avenues of absorption?

(d) How can one estimate, by the examination of the environmental conditions which set the stage for exposure to, and absorption of, the material, the extent of the danger of human exposure or absorption, and by a mere quantitative extension of this question, what are the specifications for safe environmental conditions?

(e) How can one establish, by the examination of workmen (including the use of clinical laboratory procedures of any relevant type), the extent of the danger of human exposure or absorption, and the proper margin of safety?

(f) What are the criteria for the diagnosis of the intoxication induced by the absorption of the material?

(g) What is the likelihood of recovery from such intoxication, and what sequelae, if any, are to be anticipated?

(h) What therapy can be given with promise of relief of symptoms and cure of the intoxication?

These are not the questions that are usually asked by the conventional toxicologist, or they are not asked in this manner. I have stated them in the terms of industrial hygiene deliberately in order to separate out from the increasingly conventionalized toxicologic procedures of the laboratory, those that have primary pertinence in the specific instance, with the following two considerations in mind:

First, the cost, in time, money, and the lives of large numbers of experimental animals, of obtaining statistically precise expressions of toxicity, such as the LD_{50}, is often much more than the usefulness of the information can justify. Careful and comprehensive observations, made on a few animals for specific purposes, may be sufficient and are often more meaningful than large numbers of tests made as a routine.

Second, it must always be borne in mind that we are concerned with the response of man to his environment, and not to the reaction of experimental animals to a set of conditions within a laboratory. One cannot translate the toxic reactions of white rats into the forms of human intoxication, without serious reservations; and moreover, the experimental conditions in the laboratory, despite or, perhaps, on account of their rigid control, are artificial and sometimes, indeed, are irrelevant.

Both of the foregoing considerations tend to be ignored unless industrial toxicology is viewed as a means to an end and not as an end in itself. Hence, it follows that the experiments in the laboratory should include appropriate observations on human subjects whenever this is possible, in order to bridge the gap between human behavior and that of laboratory animals. It is equally necessary that the capstone be put on the structure of our toxicologic information, for the purposes of industrial hygiene, by transferring the site of the investigation from the laboratory to the industrial plant. By a judicious examination of the environmental conditions, in concert with general and selected clinical observations on the men who work under such conditions, the basic data of industrial hygiene are gathered. This brings us to the next field of research, not because it is different in its aim, but because, in general, it is carried out by different persons and by somewhat different methods.

Industrial Hygiene

Unfortunately, the term "industrial hygiene," especially in the United States, where it has suffered from fairly general misuse, must now be defined before it can be used. As used herein, and as a decent respect for linguistic precision requires, it comprises the means employed within industry whereby the health of the industrial population is protected and promoted. To be more specific, it includes the measures of environmental appraisal and control, from the aspect of its threats to human health, as well as the measures applied to industrial personnel whereby the impacts of the industrial environment upon human health and disease are explored, interpreted, and manipulated beneficially.

The personnel involved in industrial hygiene in much of American industry are composed of the engineer, as one part of the team (including the industrial hygiene engineer, the health physicist, the safety engineer, the process engineer and the production engineer), whose province it is, collectively, to create, appraise, and control the environment; and the physician, on the other, (with the related and ancillary personnel of medicine and biology, which usually include the nurse, and may include the personnel of general or specialized clinical laboratories, the psychologist, the physiologist, and optometrist, the social service worker, the first-aid assistant, and certain others from time to time, as technical advisors or assistants), whose function it is to learn man's response to specific environmental hazards, and to differentiate between those that are innocuous and those that are harmful.

To speak of the practice of industrial hygiene as research is merely to state the facts of daily experience among the professional people in industrial organizations who are alive to problems of human health that stem from modern technological developments in industry. Two aspects of these problems deserve special comment, both on their own account and as illustrations of the investigative challenge and approach.

The one is concerned with the development of methods for the sampling and measurement of new chemicals or new forms of energy (or for the detection and measurement of such agents in circumstances or conditions under which they have not been encountered previously), and with the adaptation of methods for their control within specified limits. The other consists essentially of a type of clinical investigation which is designed to discover some response on the part of individuals or groups of persons to certain environmental factors which are known or suspected to be harmful when they reach a certain level of intensity.

Prior investigation in the toxicological laboratory, or perhaps prior industrial experience, may have provided clues which need to be followed with care for their applicability to human beings. The responses sought for may be in the form of symptoms, physical signs, or deviations from normal hematologic, radiologic, excretory or other physiological standards derived from the microscopic, chemical or physical observations and measurements of the clinical laboratory.

It is obvious that in many, if not all, instances, the technical appraisal of environmental factors must be coordinated closely with the clinical appraisal of personnel. Parenthetically, in this period, when the working relationships of the engineer and the physician have not been developed fully and widely, one must view with tolerance, as well as concern, the controversy that arises from time to time within these professional circles over the relative importance of the two approaches.

Time and space will not allow us to discuss in any detail the problems of industrial hygiene that are amenable to the methods of investigation here suggested, or to remark upon the many methods by which they may be attacked. Suffice it to point out, however, the general applicability of such programs of research, and to cite the urgent need for their wider development in industry. First, it is necessary to emphasize the fact, all too obvious to those who have responsibility for the safety of men who work in dangerous or potentially dangerous occupations, that we have very few standards of industrial safety which have been subjected to the test of systematic environmental and clinical appraisal and can now be said to be firmly established.

How many of the "maximum allowable concentrations," so glibly known as the M. A. Cs., and so readily contemplated for inclusion in the statutes of the land, have been substantiated in this manner? And, if I may venture an aside that concerns itself with our professional responsibilities, how many of the investigations of this type that have been carried out partially or completely in American industry, have been published? We as industrial physicians must not be deceived, and moreover we must not be complacent. Let us recognize and admit that there are no acceptable standards of industrial safety with the exception of the few that have been substantiated by adequate clinical evidence under known conditions of human exposure. Let us also recognize that no such standards will exist until we stir ourselves to initiate and carry out the investigations required for the purpose.

Industrial Endemiology

Epidemic diseases may occur in the industrial population and require investigation by the accepted methods of this field. Of much greater and more general concern for present purposes is the approach to the endemic diseases of occupation and to that increasingly significant group, the degenerative and metabolic diseases and the aging processes, which may conceivably be influenced in their incidence and of course by the general or specific hazards and stresses of occupation.

If it is something of a departure from current speech to refer to this field of investigation as "Industrial Endemiology," some justification, other than that of semantics, can be found for such departure at this time, in that the methodology to be employed is incomplete at best and is so meager in its present application as to deserve some special attention from industrial physicians. This is not the time or place for a detailed discussion of this type of research or of the methods which must be developed and perfected if it is to bear sound fruit. Suffice it, for our purposes, to state certain basic conditions which must be met before such a discipline can be brought into actual existence.

The deviations from a normal state of health which are induced by occupational factors may be both acute or chronic in the individual case, just as they may be obvious or obscure in their influence upon the various occupational groups in an industrial population. Thus we have overt occupational injury or disease, which may lend itself readily to diagnosis, and also, perhaps, to effective preventive measures; or we may have insidious injury, or a specific disease process so gradual in its onset, or so similar in its effects to those of nonspecific wear and tear, as to go entirely without recognition or remedy.

In none of these situations will the incidence of the injury or illness be evident, nor will the true significance of the environmental conditions be learned, unless appropriate and properly timed clinical observations are combined with precise and well co-ordinated measurements of the environmental factors. Furthermore, even the best of such observations will fail to serve their ultimate purpose and to justify fully the effort and expense which has gone into their procurement, unless they are recorded in such a manner as to be both explicit and accessible. The full meaning of these words can be appreciated only after some elaboration.

In the practice of occupational medicine the job is not finished when a diagnosis has been made and confirmed in its etiologic relationship to an occupational factor, or when the patient has been handled properly. Indeed it is only well begun, since the case becomes the focal point for an investigation, on the one hand, or the substantiating evidence of the existence of a hazard which has been in question or under investigation, on the other. At the least, it becomes a vital statistic, which, both as a fact in itself, and as a part of the larger body of facts that may serve well in the elucidation of a disease, should not be buried in the records.

There can be no doubt that the incidence of various diseases of occupation in the United States is far greater than any of our public records would lead us to believe. Any physician or investigator who digs beneath the surface of the available data in any direction can establish this truth for himself. The factors which contribute to this situation are numerous, but three of them are of primary importance.

(1) The large proportion of the industrial plants of the country, especially the small plants, operate without benefit of medical and hygienic supervision, and, of course, without any medical records. The occupational diseases which occur within them must be well understood and obvious, if they are to be recognized as such by physicians in general practice, and not all of those recognized are reported.

(2) Another large segment of these industries have only such medical advice and supervision as may be provided by physicians whose main interests and abilities are devoted to other types of medical practice, and they obtain only such benefit of industrial hygiene engineering as can be offered by technical and production personnel whose chief competence lies in other technical fields. Under these conditions also, occupational disease of mild or chronic character occurs unnoticed as such.

(3) Even within the relatively small group of industries in which the employees are well supervised medically and hygienically, the records of specific employment, and those concerned with initial and periodic medical examinations, are usually so poorly adapted to the requirements of statistical analysis, that the information contained in them, accurate and potentially useful as it may be, is almost utterly inaccessible because of the time and expense required to assemble it. From the aspect of the vital statistics of health and disease, the result is essentially the same as if the recorded observations had never been made.

The importance of good medical and hygienic records, in the care and supervision of industrial employees, has been stressed frequently, and the emphasis on this point has resulted in a considerable improvement in industrial medical records in recent years. There is much less recognition, however, of the importance of making use of modern techniques of recording which facilitate prompt and productive statistical surveys of the accumulated data.

The careful, skillful periodic examination of industrial employees provides the raw data without which no study of occupational disease or stress can be carried out, and nothing that is done thereafter with such data can render them one bit more precise or trustworthy. They are the grist of endemiological investigations in industry, and without such grist of high quality the procedure is doomed to sterility. Under ordinary circumstances, however, these data must be handled with imagination and competence and with an understanding of their significance, if they are to serve the purpose of revealing the hygienic status of a segment of the industrial population.

To this extent, the industrial physician, with his observations on employees made through years, perhaps a lifetime, of employment, is the primary investigator in the field of industrial endemiology. To be sure, a survey of an industrial population, made on one occasion by a competent team of medical and engineering investigators, can learn much about the immediate status of the employees and about the industrial hazards of an industry or series of industries. Nevertheless, the true picture of the situation can be revealed only by systematic and comprehensive observations made over a long period of time. There is no adequate substitute for in-plant medical and hygienic supervision, for the purposes either of securing the facts or doing something about them.

The application of industrial endemiology to the field of public health, as the latter is influenced by the spread of industrial hazards into the community generally, may require some adaptations and modifications, which at this time must be left for future consideration. It is neither irrelevant nor premature, however, to call attention to the fact that the effects, upon human health, of the pollution of water and air, soil and food, with industrial products and wastes, can hardly be known in their significance, until not only suitable techniques but also appropriate means for the field application of such techniques have been developed for the investigation of large numbers of persons in the general population. It seems reasonable to suppose that such means of investigation can best be developed and tested for their sensitivity and practicability within industry, after which they can be applied, with the necessary modifications, to the broader problem.

A Resumé of the Function and Purpose Of Columbus Receiving Hospital For Children

NORMAN S. BRANDES, M. D.

COLUMBUS Receiving Hospital for Children, located at 800 North Nelson Road, Columbus, Ohio, is a long term, intensive, inpatient psychiatric treatment center for emotionally disturbed children, which has a functional relationship with other agencies in the community that care for children or offer help to emotionally disturbed children. It also has the same relationship with Ohio state-wide facilities.

Unlike institutions for delinquent children, orphaned and mistreated children, and schools for disabled children, etc., a children's psychiatric hospital has a certain definition. It is a medical institution which has the function of the diagnosis and treatment *in residence* of children with psychiatric disorders. It provides around the clock treatment for children whose needs make such a regime the treatment of choice, in distinction to outpatient or other types of treatment. Decisions about intake and discharge, based upon diagnostic and therapeutic findings, are made by the staff of the hospital consisting of the psychiatrists in charge and the social case workers, psychologists, teachers, and child care workers.

Selection of Children

Not all children who need psychiatric help require the specialized services of an inpatient psychiatric treatment center for children. They can be given psychiatric aid while they live in their own homes, while they are in foster homes or in a nonmedical institutional setting. Columbus Receiving Hospital for Children admits only those children who cannot be treated in such places and who must be removed from the family constellation and given intensive treatment while the members of the family are treated intensively as outpatients!

The geographic source of referrals of the children of Columbus Receiving Hospital for Children is 70 per cent Franklin County and 30 per cent outside of Franklin County. Child Guidance clinics, private physicians, pediatricians, church-sponsored guidance centers, as well as schools and boards of education in various communities can make referrals to the Columbus Receiving Hospital for Children. A social case history, or suitable substitute, as well as some basic psychological testing is necessary at the time of referral. This material helps the staff to screen out in advance those cases which would be undesirable for treatment.

Once the staff decides to perform the initial psychiatric intake examination on the family, then all parental figures concerned as well as the child are given intensive examination including psychological testing. This information is presented to the entire staff at the time of the intake staffing on a weekly basis. The intake staffing takes anywhere from one hour to one and one-half hours to complete. After a discussion of the entire history, the staff, by vote, renders a decision as to whether or not they want to take the child. If the child is not accepted, then a recommended disposition is made to the source of referral.

Reasons for Selectiveness

The psychiatric intake process is highly selective for many reasons. First of all, a maximal investment of money, time and energy is made in the treatment of each child. Admitting more children than the number for which Columbus Receiving Hospital for Children can provide adequate care and treatment would jeopardize this focus of investment. Also, there is the risk that possible jeopardization of treatment for the group of children already in residential care may take place by the admission of children who may be disruptive to the therapeutic group or who have types of psychiatric disorders that the staff and hospital are not equipped to treat. Some mentally ill children are untreatable within the limitations of our present knowledge and treatment techniques. Therefore, the intake policy is so geared that only children with psychiatric disorders that can hopefully respond to treatment are admitted to this hospital.

Psychiatric hospitals which treat children are

The Author

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responsible for the acts of the children under their care and for what they do both on the hospital grounds and elsewhere in the community. It is therefore necessary to take only those children which would not be threatened by the "openness" of this particular institution. There are no closed facilities available at Columbus Receiving Hospital for Children. There are gasoline stations, heavy traffic, a creek and other hazards and sources of potential difficulty for children which are accessible on the property or near the property. Severely disturbed psychiatric children who cannot distinguish between right and wrong and who are unable to accept limits cannot be admitted to this "open hospital" because of these dangers.

Some day, if we are ever granted the facility of a closed unit, then we can take such children. At this time, it would be extremely unfair to the child and place the hospital in a dangerous position of accepting responsibility for which it is not geared to handle. Children who have the primary problem of brain damage, epilepsy or mental retardation and who *are not* emotionally disturbed are not eligible for admission to Columbus Receiving Hospital for Children. However, many of our children do have minimal brain damage, epilepsy and impaired intellectual endowment *but* their basic problems are emotional in nature.

There is a definite age restrictiveness with regard to the intake. Only children between the ages of 6 and 11½ can be admitted. In other words, Columbus Receiving Hospital for Children deals only with the problems of the school child (not the preschool or adolescent group).

The Definition of Staff And Its Functions

The following personnel are necessary to satisfactorily manage an inpatient psychiatric facility for children, such as Columbus Receiving Hospital for Children: (1) Psychiatrists, (2) psychiatric social case workers, (3) psychologists, (4) child care workers, (5) teachers, (6) a consulting pediatrician, (7) cooks, (8) maintenance and cleaning people, (9) a business staff and secretarial staff. In addition, it is necessary that an active Board of Directors, properly constituted, work with the hospital in order to give the hospital roots in the community and to support and interpret the hospital's therapeutic program to the public. It also represents the community's interest in the work of the hospital. These are but some of the necessary functions of a Board of Directors for a children's inpatient psychiatric facility, such as the Board of the Children's Mental Health Center, Incorporated.

It is the obligation of the administrative and treatment staff of the hospital to communicate in an understandable way with its Board of Directors so that members of the board can know just what the hospital program is all about. The language and application of psychiatry can be quite complex and unless the staff of a children's inpatient facility for psychiatric treatment communicates its feelings, treatment policies and other important roles to the board, then a great gap of misunderstanding exists which certainly cannot be as constructive as the more positive approach of good communication.

The recommended ratio of child care workers to each child should be one worker to three children. This ratio was agreed upon as necessary by the conference on inpatient psychiatric treatment for children held at Washington, D. C., October 17-21, 1956, under the auspices of the American Psychiatric Association and the American Academy of Child Psychiatry.[1]

While the children are in residence and in treatment, the child care workers serve as their parental substitutes. They provide shoulders for the children to cry on, set limits on acting out children, and focus upon children who find it necessary to withdraw into fantasy and unreality. The workers more or less integrate the children's activities and supervise the children's behavior from the time they get up in the mornings until the time they go to bed at night and through the night while the children sleep. The child care workers of Columbus Receiving Hospital for Children are considered to be "milieu therapists."

Milieu Therapy

A simple definition of milieu therapy may be said to be: "The concentration of therapeutic techniques on the everyday behavior, interpersonal relationships and problem situations of the patient by trained personnel, in group and one-to-one realistic situations." Our child care workers are college graduates, within the age range of 20 to 30. They must have stable personalities, be mature individuals, and demonstrate an inherent capacity for withstanding the emotional impact of dealing with our emotionally disturbed children. Therapeutic interaction with the child in residence takes place in the play areas, at the dining tables, and in the environment of the hallways and bedrooms.[2]

The clinical psychology department is responsible for the psychological intake process on the child. Such testing may reveal evidence of brain damage or severe psychopathology. The clinical psychologists are assigned case loads in therapy under the supervision of the assistant superintendent. This section of the hospital participates in the supervision of the school teachers and helps to coordinate planned projects involving the children with the therapeutic recreational activities of the child care workers.

It is a fundamental principle of our society that public education must be available for all children. It follows, therefore, that each child be afforded an opportunity to engage in an educational program that is commensurate with his ability, so that he may make maximum use of his intelligence and capabilities, and thus, be better equipped to resolve his problems of living. The educational needs of our emotionally disturbed children are met within this institution. A staff of three well qualified and trained teachers, under the supervision of a psychologist and the psychiatrist in charge, formulates a school program with special emphasis on academics and remedial reading. This educational program is patterned very much after the public school system.

Children are divided into small groups of four and five to a class. All groups rotate through academics, crafts, recreational periods with the child care workers and other activities necessary in their cultural and social as well as educational development. The educational program of Columbus Receiving Hospital for Children is fully approved by the Columbus Board of Education and the State Board of Education. Although many of our children have a normal, or even above average endowment, nevertheless, a sizable portion do require special learning techniques and remedial sessions.

Psychiatric Social Case Work

The role of the psychiatric social case work department in a children's psychiatric hospital brings the social case workers into much closer contact with treatment and administrative functions than in other psychiatric institutions. Under the close supervision of the psychiatrist, the social case work department handles all referrals from initial telephone calls or letters to the staff presentation of its history. Also, under psychiatric supervision, the members of this department are assigned parents and children in individual therapy.

The social workers are directly responsible for the activities of the child care personnel and the dietary department. The last function of the psychiatric social case work department is necessary because food must be prepared and served to the children with as many wholesome attitudes as possible. The cooks, being human beings, could not possess such beneficial attitudes in the kitchen unless they were helped with their own interpersonal problems of living. Therefore, one of our social case workers is assigned to be in direct charge of the dietary service. This department has a definite community responsibility inasmuch as it relates to other community agencies, organizations and professional individuals in the field of mental health in order to share common knowledge, facilitate treatment and provide for mutual understanding.

In addition to the clinical psychologists mentioned previously, the institution employs a research psychologist who directs, with the assistance of the psychiatrist, a far reaching group of research projects. The basic research project to which this department will be devoted is "Project No. 49." This rather complex research project which has been going on for several years has the purpose of determining the effectiveness and applicability of various forms of treatment being used today in child psychiatry. It is hoped that information obtained from the results of this project as well as other associated projects will definitely help national agencies and local agencies in terms of providing a better comprehension of what to do with emotionally disturbed children. It will also serve the secondary function of providing very important material for the use of public and private schools.

Definition of Treatment

The psychiatric treatment of emotionally disturbed children may be defined as follows: "The application of milieu, recreational, individual and small group techniques, as well as educational and remedial techniques, to the problems of living that each child admitted to the institution experiences, so that the child can eventually develop more healthy and comfortable methods of handling these problems of living for himself." Therefore, in addition to the educational and milieu programs described, there are also individual therapy and child guidance sessions offered the parents by means of weekly outpatient appointments and individual psychotherapy offered to some of the children on a three hour a week basis.

These therapy loads are assigned to the staff members and are also assigned to trainees, such as social case work students, psychological interns and psychiatric residents in training, under the close supervision of the psychiatrist. One of the obligations of a psychiatric hospital for children located so close to so many colleges, social agencies and hospitals is to provide training for people who will hopefully stay in our state community and engage in mental health efforts. It is well known that there is a tremendous shortage of qualified, well-trained personnel in not only the field of child psychiatry but in the field of mental health.

When a child becomes upset or experiences an impulse to act out, such as breaking a window, taking a brick or large stone and smashing plaster out of a wall, or hitting a staff member or another child, then external limits must be imposed. Columbus Receiving Hospital for Children does not use straight jacket techniques, tubbings, punitive controls or electroshock therapy as methods of controlling antisocial or acting out behavior. Instead, we have throughout the building "freedom rooms" or quiet rooms. If the child infringes or acts out against another member or members of his peer or adult group situation, then he is put into one of these freedom rooms by the worker or adult that has been infringed upon for a period of 10 minutes to perhaps 30 minutes.

"Freedom Rooming"

During this time the child can scream, curse, kick his feet or simply sit in solitude until he is less upset and feels once more that he can join his social group. Thus, the freedom room technique of isolation for upsetment in children has two meanings: (1) To act as an external control for the child so that he can build up his own internal controls for the future and (2) to provide an atmosphere of privacy, seclusion and isolation so that an upset child can experience his right to be upset, sort of "get it out of his system" and then return to his group.

The children accept the isolation technique amazingly well. Although sometimes they kick and fuss (thus requiring two or three workers to hold a fairly husky boy and bring him to the freedom room) nevertheless, they learn to respect the meaning of the freedom room and isolation. They learn that it is not a place to be feared and they expect "freedom rooming" if they infringe. In this way, a base line is built up for each child on which he can build his own self-controls so that he will become a more acceptable member of his community not only in the hospital setting but after he is discharged from the hospital. Occasionally, the children *will ask* workers or other personnel to place them in the freedom room if they are upset, for a short period of time.

Staffing is Intensive

Each case in therapy and in residence in this institution is staffed on a rotating basis. These confidential case presentations are held three times a week. Each therapist involved in the case reports on the progress and asks the staff for its opinion as to prognosis and disposition. The teachers and child care workers who are closely involved with the children in their milieu activities report on the progress and behavior of the children at daily staff conferences as well as during the therapy presentations. Thus, a very close check is kept on the treatment investment made in each family and in each child. Only when the staff feels that further investment is useless or that investment has paid off and maximal hospital benefit has been achieved is the child discharged from Columbus Receiving Hospital for Children.

In the past, several families have withdrawn their children from treatment, as will happen in any open, voluntary type institution. Occasionally, the staff makes an incorrect prognosis at the time of admission and takes a "sicker" child than it is geared to handle. When this happens, the child is usually referred to another agency. For example, not too long ago we admitted an extremely psychotic child and it was necessary to refer this child to the local state hospital because he would have to wait too long to be admitted to the closed unit at Longview in Cincinnati.

Summary

A description of the referral technique at Columbus Receiving Hospital for Children together with comments and descriptions about the staff, treatment, and the functioning of the hospital, has been outlined in the foregoing. Sometimes, very little therapeutic reward is obtained except over a very long period of time. It is felt that this particular hospital has a group of devoted staff members who work at their jobs with one common goal in mind: *The treatment of the emotionally disturbed child which has been admitted to its care and responsibility.*

Every staff member at this institution from the psychiatrist in charge to the cleaning personnel has an important role to fulfill: *To prevent severe adolescent and adult psychiatric difficulties and to produce a future healthy member of our familial and sociocultural community.*

References

1. Gardner, G. E., and Greenwood, E. D., et. al.: Psychiatric Inpatient Treatment of Children. 1601 Edison Highway, Baltimore 13, Md., American Psychiatric Association, 1957.

2. Brandes, N. S.: Some Possible Meanings of the Hallway Interview. J. Nerv. & Ment. Dis., October-December, 1957.

Problem in Management Of Rheumatic Fever

The extreme problem in the management of rheumatic fever is not the treatment of the symptoms of pain and fever nor the signs of brain, joint or skin involvement, but is the management of acute carditis and/or its complications. All other signs and symptoms of rheumatic fever are reversible and self-limited with or without treatment. The carditis of the initial attack may be self-limited or respond to therapy but with an increasing number of subsequent attacks this becomes wishful thinking and congestive failure invariably results.—Jos. R. Christian, M. D., Chicago: *South Dakota J. Med. & Pharm.,* 11:360, Sept., 1958.

MATERNAL HEALTH IN OHIO

TOPIC THIS MONTH:

Maternal Deaths* Involving Toxemia

Case No. 208

This was a 23 year old, white, gravida I, Para O, eight months pregnant who died seven hours after cesarean delivery. Her family history was remarkable in that her mother had had eclampsia with two of her pregnancies and her aunt had died of eclampsia! Her past history was not significant. The prenatal care was competent and adequate. A presumptive diagnosis of twins was made and confirmed by x-ray on August 14 at 30 weeks gestation. Her last prenatal visit was September 17 (35 weeks) at which time she had normal urinary findings, blood pressure 120/70, weight 138 pounds, no edema.

She was next seen at 10:00 a. m. September 19 in the hospital emergency room in a generalized convulsive state. She was given 7.5 gr. Sodium Amytal®, 2.0 gr. sodium phenobarbital, 10 cc. 50 per cent magnesium sulfate intramuscularly and 0.5 cc. Verenteral® intravenously; 7.5 gr. Sodium Amytal was repeated in 20 minutes; 5 cc. of Verenteral in 500 cc. 5 per cent glucose was given by slow drip. The initial blood pressure was 160/110. It gradually declined under therapy.

At 12:00 noon September 19, she was given 100 mg. Demerol®, and thereafter she was given 50 mg. intravenously at intervals. An indwelling catheter was inserted. By 4:30 p. m. she had put out 15 cc. of urine which showed 2 plus albumin. By 8:00 p. m. she had put out 30 cc. which showed 4 plus albumin. Surgical emptying of the uterus was vetoed at this time because of anuria. Blood chemistry the afternoon of admission showed blood urea nitrogen 15.0 mg., uric acid 4.8 Gm., CO_2 combining power 12.4 vol. % She received 1750 cc. of fluid from 7:30 a. m. to 3:00 p. m. and another 3300 cc. from 3:00 to 11:00 p. m.—a total of 5050 cc. in the first 12 hours of hospital admission. Total output during that time was 470 cc.

The next morning (September 20), the patient seemed to have improved. Blood chemistry then showed blood urea nitrogen 18.5 mg., uric acid 6.0 Gm., serum sodium 120.0 mEq., serum potassium 3.4 mEq., CO_2 combining power 16.0 vol. %, the serum chlorides 107.7 mEq.; the fetal heart was audible; the urinary output from 7:30 a. m. to 3:30 p. m. was 350 cc. After urological consultation cesarean section was approved.

Sometime between 5 and 7 p. m. the patient vomited and supposedly aspirated vomitus for she went into respiratory failure and cyanosis. Pulse rate 120, respiration rate 28. A bronchoscope was passed and a quantity of frothy white fluid was obtained. There was some question whether this was pulmonary edema fluid or vomitus. The fetal heart sounds disappeared during this episode. On September 20 (at 35 weeks gestation) a classical cesarean section under local anesthetic was done (shortly after) with the delivery of stillborn twins. Following surgery the patient experienced a short period of stability but respiratory difficulties continued. All heroic measures for the treatment of pulmonary edema were done but to no avail. Death occurred on September 21, seven hours postoperative. Autopsy permission was not granted.

Cause of death: Fulminating eclampsia; acute pulmonary edema.

Comment

The majority of the Committee felt that this was a nonpreventable death. One member questioned the element of surgical interference after the death of the fetuses. Another member expressed concern over the amount of barbiturates administered. On the whole the Committee felt that the case was carefully managed and was complimentary in the appraisal.

As a minority member, this reviewer felt that the patient was over-treated and over-studied. The initial treatment is a matter of individual preference and experience. In cases of fulminating toxemia no more than five to six hours should be spent in evaluating the patient, stabilizing the patient, and making sure she is well oxygenated. Anuria in toxemic state should not rule out emptying the uterus by cesarean section. The uterus should be emptied in the easiest and quickest way possible. The writer felt that procrastination was a glaring fault here. The next biggest complaint was the 5000 cc. of fluid given in the first 12 hours of hospital admission. This brings to mind five similar cases reported by Mengert several years ago in which he attributed the cause of death

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*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by official representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

to excessive use of fluids in the treatment of toxemia.

Case No. 126

This patient was an obese 38 year old, colored, gravida XII, Para VIII, abortus III, at term who died one and one-half hours postpartum. Her past history showed bronchial asthma. No prenatal care. She was admitted to the hospital at term, in active labor. On admission hemoglobin was 7.0 Gm., blood pressure 210/110, massive leg and ankle edema, 3 plus albuminuria, moist rales in both lung bases and a frank breech was presenting.

Chronology of labor and delivery: 3:25 p. m. admitted, membranes intact, labor active; 7:00 p. m., cervix completely dilated, good labor pains; 9:05 p. m., open drop ether started, scopolamine 0.4 mg. given beforehand; 9:15 p. m., patient developed laryngeal spasm, blood pressure dropped to shock level. She was intubated and bag respiration started. The blood pressure came up; 9:52 p. m., breech extraction started; 9:55 p. m., cardiac arrest, thoracotomy performed with cardiac massage; 10:05 p. m., breech extraction completed with delivery of stillborn 9 pound 12 ounce male; 11:30 p. m. patient expired. No convulsions were recorded. Autopsy permission granted.

Cause of death (certificate): Puerperal eclampsia; contused heart; hypertensive cardiovascular disease.

Pathological Diagnosis: Cardiac Hypertrophy and Dilatation; Contused Heart; Acute Myocarditis; Focal Necrosis of Liver; Proximal Tubular Necrosis of Kidney; Pulmonary Atelectasis and Hyperemia.

Comment

The Committee voted this a preventable death of patient's responsibility; she had not sought prenatal care. There was some question as to why the state of toxemia was not treated. Even though blood was available there was no attempt to treat the state of anemia. The patient's oxygen needs from the standpoint of toxemia, obesity, congested lungs, color of skin, open drop ether, anemia and general pregnant state were poorly evaluated. The Committee surmised that it might have been easier and safer to have left the patient alone and to allow her to deliver the breech spontaneously with 100 per cent oxygen by mask, and use every little anesthesia. The Committee's final vote succeeded by a narrow margin over personnel responsibility.

Case No. 186

This patient was a 24 year old white, gravida I, Para O, at term, who died two days postpartum. Her past history was not remarkable. Her prenatal care was adequate. The prenatal course contained several interesting facets. She had severe nausea and vomiting starting two weeks after conception and lasting for the first four months. This necessitated two separate hospital admissions for rehydration and extra care. The second and third trimester was characterized by a voracious appetite. She had a 40 pound weight gain, none of which could be attributed to fluid retention. She was negligent about her prenatal visits the last two weeks before admission, when questioned by phone she said she was "too busy."

On receiving a frantic phone call from the husband that his wife was convulsing, the attendant made a home call and found the patient in a coma. Her blood pressure was 240/120. She was hospitalized. Labor ensued spontaneously, and after nine hours of hard labor a stillborn 7 pound fetus was delivered by low forceps and mediolateral episiotomy; no anesthesia. Very little blood was lost after delivery. There was no record of therapy except a notation that convulsions were controlled with difficulty.

Shortly after delivery the patient went into shock. Routine shock therapy was instituted. Blood was given. Shortly afterwards renal shutdown was noted and she was transferred to another hospital for the use of an artificial kidney. Death occurred one day, eight hours, and 20 minutes after delivery. An autopsy was permitted.

Cause of death (certificate): Acute hyperpotassemia; eclampsia of pregnancy; acute renal shutdown.

Pathological Diagnosis: Extensive focal necrosis of liver; retrogressive changes in the convoluted tubules of kidney; bilateral marked pulmonary edema; petechial hemorrhages of myocardium and liver; cerebral congestion and edema; generalized acute passive congestion.

Comment

The Committee voted this a preventable death, the patient's responsibility. The members emphasized the importance of frequent prenatal visits during the last four weeks of gestation. There was some question raised as to the advisability of making a home call on a patient at term in convulsions. Some valuable time for definitive treatment may have been lost. There was no record of blood chemistry finding to support the first diagnosis listed in the cause of death.

Comment of Consultant

The following comment of a consultant who is a specialist in obstetrics and gynecology, was given at the request of the Committee.

Case No. 126 provides a somewhat unusual opportunity to combine hindsight and foresight. Here is a patient admitted to the hospital with hypertension, albuminuria, marked anemia, indications of cardiac decompensation and a full term breech and in labor. Her labor was reasonably short and nearly devoid of medication. During delivery she developed laryngospasm and blood pressure collapse to shock level. The autopsy findings are with the case report.

The Committee voted this death preventable although it's not easy to see just what in the way of treatment would have offset her overwhelming combination of pathology. Certainly if there is any blame it is on the patient. On the other hand, suppose she had been intensively treated for hypertension then the question might have arisen if "overtreatment" had not caused her blood pressure collapse. Admittedly she was in bad shape for hemoglobin but she was not a good subject for adding much of anything to the load on her heart.

Open drop ether might be open to question but the attending physician can be glad he hadn't given a spinal since her blood pressure collapsed, or Pentothal® since she had laryngospasm or magnesium sulfate since she developed cardiac arrest. Had he used any of these drugs they would certainly have been held to blame for these conditions which, it so happens, the patient developed without them. It is easy to say since she died she might better have been left to deliver spontaneously but had she been allowed to do so she would surely have died anyway and then the question would have arisen as to why some attempt had not been made to expedite the delivery. Had she survived the delivery she surely would not have lasted long and her life would have been a burden, as it probably was before.

Case No. 186 illustrates a popular fallacy among patients. A great many of them seem to think that prenatal checkups stop at term no matter how long labor may be delayed. I would certainly question the statement that she gained 40 pounds *none of which could be attributed to fluid retention.* I recently saw such a patient who lost 14 pounds in two days of hospitalization on the same diet she claimed she had been following at home.

In contrast to the previous patient this one received blood and no ether but the result was the same. Patients with any appreciable degree of the pathology found in either the kidney or liver seldom survive for long. The combination is far deadlier. So great is the current interest in electrolytes that anyone signing a death certificate in a case of this kind without mentioning them, like the teenager without braces on her teeth, feels sort of out of things.

Case No. 208. I am inclined to agree with the reviewer who thought this patient was overtreated and overstudied. This last term is new to me but I think it is a good one. It seems to me that the dosage of barbiturates and narcotics was pretty steep although I've never been suspected of Homeopathic tendencies. It seems to me that the most significant laboratory finding was the CO_2 and yet the treatment of the acidosis seems to have been pretty casual.

Failure to do a cesarean section during the anuric period may or may not have been a mistake but it is very doubtful that anything would have altered the outcome and the attending physician anymore cannot always use his own best judgment. He has to keep one eye cocked on the consultation requirements of the accreditation boards and the other on the maternal mortality survey board. He is apt to proceed with caution under such circumstances when boldness may well be what's called for.

Back about 1938 in *The Journal of the American Medical Association,* Nelson made a very good case for the use of large quantities of water where the concentrating power of the kidney was low but his suggestions probably would not be applicable in the face of almost complete anuria.

Milk-Alkali Syndrome with Jaundice and Tetany

Hypercalcemia and the accompanying calcinosis is not peculiar to the milk-alkali syndrome, yet hypercalciuria is not generally found. The fact that urinary excretion is not excessive suggests some interference with the renal excretory mechanism. Alkalosis, almost invariably present, probably plays the most important role in initiating the kidney impairment. It has been demonstrated that urinary calcium clearance is diminished by alkali administration, and Burnett and his associates showed significant reduction of renal clearance mechanisms resulting from alkalosis subsequent to pyloric obstruction. Upon correction of the alkalosis, decided improvement was manifested, leading to the suggestion that this renal insufficiency resembles, in some respects, lower nephron nephrosis. Renal failure associated with hypercalcemia has been observed in hyperparathyroidism, myelomatosis, vitamin D intoxication, skeletal immobilization, sacroidosis and carcinomatosis with generalized bone involvement. Yet the hypercalcemia and renal failure in the milk-alkali syndrome will not likely arise from excessive calcium intake alone unless alkalosis is also present.

The kidney deterioration may be furthered by the hypokalemia frequently associated with alkalosis. In addition to the gastrointestinal loss, the high serum bicarbonate facilitates the transfer of potassium from the intracellular compartment and the entrance of sodium into the cell. Additional potassium loss is incurred by the inability of an already impaired kidney to conserve potassium. In a report of one other case in which muscular twitching was present, the author expressed the belief that hypokalemia was crucial in the causation of the metabolic alkalosis and the genesis of the milk-alkali syndrome.

Elevation of the pH, of serum sodium and potassium ions may result in heightened muscle excitation. . . .

Confusion in the differentation from primary renal disorders is to be anticipated in this syndrome, yet infrequently in cases reported is there suggestive evidence of previous renal disease. The changes expected with chronic nephritis—metabolic acidosis, hypocalcemia and hyperphosphatemia—are not present. Further, the rapid reversal of the azotemia and the renal failure pattern as soon as the ingestion of the alkali and milk is discontinued, probably gives the most impressive clue to the proper diagnosis of this syndrome. The serum calcium may fall to normal levels within one to two weeks.—Abraham A. Goetz, M. D., Sunnyvale, Calif.: *California Med.,* 89:136, Aug., 1958.

A Clinicopathological Conference

Edited Under the Auspices of the Ohio Society of Pathologists

WILLIAM SINCLAIR, M. D., *President*

> ### *Presented by*
>
> - **Wiley Forman, M. D., Columbus, and**
> - **Emmerich von Haam, M. D., Columbus.**
>
> **Edited by Dr. von Haam.**

Presentation of Case

THIS was the first University Hospital (Columbus) admission of this 41 year old white male, who complained of severe shortness of breath over the past two years. The patient had measles and whooping cough in childhood, but neither disease was complicated by pulmonary symptoms. He had his first attack of pneumonia at the age of 12 years. Between the ages of 9 and 27 years he worked on a farm doing mostly baling and threshing, and was so bothered by the dusty atmosphere that he wore a dust mask for a time. He changed his job to driving a milk truck but noted shortness of breath, especially when lifting milk cans.

At the age of 32 he had a second attack of pneumonia, following which he spent eight months in Tucson, Arizona. At the age of 40 he was hospitalized for two weeks for his third attack of pneumonia and during this hospitalization he required continuous oxygen administered by an oxygen tent. Ten days later he was readmitted for treatment of a ruptured appendix. During this hospitalization he required intermittent oxygen and from then on he required oxygen intermittently for six months, after which he was on continuous oxygen administration.

Recently he had been using Isuprel® in a nebulizer with some temporary relief. He was also on Delta Cortef,® 5 mg. two or three times daily; Diamox®, 250 mg. in the mornings from time to time; and Equanil,® 400 mg. four times a day.

Blurring Vision

In the three weeks prior to admission he noted relatively rapid blurring of vision, which progressed to the point that he was unable to recognize individuals clearly. He had a chronic cough productive of small amounts of yellow sputum over unspecified periods of time, and had been troubled with frequent frontal headaches which occurred most often in the evening. During the hospitalization for his third attack of pneumonia he developed epigastric pain relieved by food. A duodenal ulcer was demonstrated by x-ray at that time and he had been on special diet since. He never gave a history of gastrointestinal bleeding. He had had nocturia of 6-7 times for an unspecified period; however, he had had no dysuria. The patient had no known allergies. He had smoked two packages of cigarettes daily for many years. His family history was inconsequential.

Physical Examination

The patient appeared in severe respiratory distress, was sitting on the edge of the bed and wearing an oxygen face mask. His skin was cool, moist and pale. His blood pressure was 120/80, his pulse 100 and his respirations 12. His chest was barrel-shaped with a considerable increase in the anteroposterior diameter. It showed marked respiratory retraction of the supraclavicular and intercostal spaces with little respiratory movements of the bony thorax. His chest was hyperresonant and the breath sounds over the right lateral chest had a bronchial quality. There were inspiratory wheezes over the right upper lung field.

The examination of the heart showed normal sinus rhythm without murmurs; the estimation of the cardiac size proved difficult. The abdomen was tense and difficult to palpate, but the liver and spleen were not palpable. The mid-epigastric region was tender. No peripheral edema or peripheral vascular abnormalities were observed. The neurological examination was not remarkable.

Laboratory Tests

Examination of the urine was essentially negative. He had a red blood count of 2.35 million, a hemoglobin of 5.4 Gm., and a mean corpuscular hemoglobin concentration of 25 per cent. His white count was 7,900 with 81 per cent polymorphonuclear leukocytes, 15 per cent lymphocytes, 2 per cent eosinophils and 2 per cent monocytes. His blood urea nitrogen was 19 mg. and his fasting blood sugar 104 mg. The serologic test for syphilis was negative. The radioactive iodine uptake was 8.4 per cent in 24 hours and excretion of radioactive iodine in the urine was 62.5 per cent in 24 hours.

X-Ray Examination

His chest showed marked generalized emphysema with several radiolucent areas in the left middle and lower lung fields suggestive of emphysematous blebs. There was dense fibrosis involving the lower two thirds of the right lung field probably associated with chronic inflammatory changes. There was also a circumscribed area of density in the left lung near the lingula. The upper lung fields appeared essentially clear. The pulmonary artery was prominent.

Hospital Course

On the fourth hospital day the patient had periods of apnea and unresponsiveness during the early hours of the morning. However, his general condition remained unchanged. The marked hypochromic anemia suggested the possibility of a recurrent peptic ulcer with hemorrhage. However, several stools were guaiac-negative and he was free from abdominal symptoms. After 2 units of whole blood his hemoglobin rose to 7.1 Gm. and he appeared more alert. The fifth day he received a third unit of whole blood and was under continuous oxygen. However, in the evening he was found again unresponsive with a weak pulse of 132 per minute, a blood pressure of 60/0, and very irregular respirations.

After 1000 cc. of 5 per cent dextrose with 4 cc. of Levophed®, his blood pressure rose to 120/80 and stabilized at 100/70. He received another 2000 cc. of dextrose with Levophed and 1000 cc. of whole blood, but did not rally. His systolic blood pressure remained between 80 and 120, his pulse varied between 120 and 130, and his respirations were irregular and very shallow. By early morning of the sixth hospital day the patient's blood pressure and respirations slowly fell to zero and he expired. Other therapy given during the last 36 hours included Combiotic® and Pro-Banthine.® His temperature remained normal throughout his hospital stay.

Clinical Discussion

Dr. Wiley Forman: Significant in the story of this 41 year old white male was his complaint of shortness of breath for the preceding two years. He had an antecedent history of having had at least three attacks of what has been termed pneumonia. It may or may not be significant that he worked for about 20 years in a barn where the dust bothered him so much that he wore a mask. The history does not state whether he had typical attacks of asthma or whether he was just bothered with bronchial irritation, but it forced him to give up his job. After a second attack of pneumonia at the age of 32 he spent eight months in Arizona, presumably at the request of his doctor "to improve his lungs." Apparently it did not do him too much good, since his dyspnea became steadily worse, although frankly I am just assuming this since it is not stated specifically in the history.

During his hospitalization for his third attack of pneumonia, and later for his ruptured appendix, he required oxygen, and he kept up this oxygen intermittently for about six months. He was treated then with the usual medications for pulmonary insufficiency, asthmatic bronchitis, or chronic pulmonary infections: nebulizers, steroids and tranquilizers. Cough is significantly absent from his protocol and is only mentioned as having been present for an unspecified period of time. I do not quite understand the blurring of his vision and his frontal headaches and whether the latter was caused by his eye troubles or by paroxysms of coughing with increasing respiratory distress. Just to complicate the picture, he developed ulcer symptoms and was put on some sort of Sippy diet with antacids, etc.

Emphysema

His chest certainly was that of a markedly emphysematous individual who also had some evidence of infiltration in his right middle lobe. The heart size apparently was difficult to percuss with his emphysematous chest but seemed otherwise normal. The abdomen was not remarkable. The slight tenderness in his epigastrium could be possibly associated with his duodenal ulcer.

His blood count showed a hypochromic anemia, which was the reason why he was not cyanotic. His white count showed a shift to the left. From his x-ray studies one would say that he had evidence of an outstanding pulmonary emphysema, pulmonary fibrosis, chronic infiltration on the right as well as on the left, and that there was some question whether the infiltrate was inflammatory or carcinoma. He had no enlarged mediastinal nodes, and these translucent areas probably represented cystic bronchiectasis. We know that people with bronchiectasis are likely to be expectorating much more sputum than this patient, but we have to accept the facts we have here before us.

I can't let this opportunity go by without making comments about several studies that I think were indicated. There was no mention here of any sputum studies whatsoever, and as glibly as we order electrolytes in this hospital, the one case where we would really like to see them has no data about blood chlorides, CO_2 or sodium. He lived in the hospital only about six days and

I suppose he was not in any shape to have pulmonary function studies done. They might have been quite revealing and confirmed the clinical impression that this patient had a chronic pulmonary disease, inflammatory in nature, with emphysematous blebs and asthmatic bronchitis, and that he was developing with his shortness of breath and dependency upon oxygen more and more symptoms referable to pulmonary insufficiency.

On his fourth hospital day, when he was still sucking up his oxygen as greedily as ever, he began to have periods of apnea and unresponsiveness. By the fifth day he was requiring still more oxygen, and something happened then and he died within a period of about 24 hours. His lungs appeared clear at this time, but his heart sounds were poorly heard. He had no appearance of peripheral shock and no evidence of acute blood loss. In spite of the usual emergency medications, Levophed and blood, he died.

The Cause

So we might ask ourselves first, what was initially the cause of his chronic inflammatory pulmonary disease which was complicated by what we presume to be asthmatic bronchitis, pulmonary fibrosis and emphysema? In this instance one may have to go back to the hayfield. He had had 20 years of exposure to farm dust in which there may have been spores of timothy, and according to the English literature these small fragments may plug up the alveolar ducts and small atelectatic areas appear in the lungs, followed by small blebs, emphysema, infection, and finally chronic pneumonitis with the clinical picture of asthma or asthmatic bronchitis depending on how much infection is superimposed.

This patient probably experienced what has been called a restrictive ventilatory pulmonary insufficiency as opposed to obstructive forms of pulmonary insufficiency. That is to say that there is something at the level of the pulmonary alveolar membrane which interferes with gaseous exchange. That is more likely to be explained on the basis of fibrotic pulmonary disease. On the other hand, if there are asthmatic symptoms with a bad lung, then there is more likely to be obstructive ventilating pulmonary insufficiency. These can be differentiated as you know by the presence or absence of expiratory wheezes on careful auscultation.

One might further ask what brought about his chronic pulmonary inflammatory disease which we think he had? I think it is probably nonspecific. I am at a loss to find any mycotic diseases that appear specifically in hay. In the *British Medical Journal* there were recently described 10 cases of "farmers' lung" and no specific mycotic infection was found. I don't think the patient had the picture of histoplasmosis, and I am inclined to dispose of other dust-borne molds—actinomycosis, blastomycosis, coccidiomycosis, etc.—because he lacked the rest of the clinical picture of adenopathy, skin lesions and other visceral manifestations.

Why did this man have anemia? There are several things that come to my mind. One is that a longstanding pulmonary infection might outweigh the mechanical effects of his pulmonary insufficiency and lead to anemia rather than to polycythemia with clubbing and pulmonary osteoarthropathy. Blood loss might account for his anemia, but none was found in this patient. Then a state of malnutrition might account for it. A certain percentage of people who have chronic pulmonary diseases of this variety get so sick and feel so badly that they simply don't eat and instead of being polycythemic they have a nutritional type of anemia.

And finally, this disease may be complicated by cancer of the lung. If he had cancer of the lung one might more easily accept the fact that he had headaches for several weeks prior to admission and that his vision blurred to the point where he could not recognize people while his fundi and his neurological findings were negative. Personally I simply mention these possibilities to get rid of them.

Cerebral Hypoxia

The next question which bothered me also was why he had blurred vision and headache. I think that the most logical reason is that this man was experiencing marked cerebral hypoxia. We have not enough information on the chart to confirm this opinion, no elevated carbon dioxide with low blood chlorides and changes in the pH, but the natural clinical course of these people explains such episodes. I think that this is probably the explanation for his headache, although it may be that he was coughing more than we realize and that may be part of the picture. I mentioned metastatic carcinoma. I don't think he had it. I mention metastatic infection to the brain. If he had a brain abscess I would not expect him to show this clinical picture and I am inclined to omit this diagnosis also.

Why then did he die? Over the years, and particularly over the preceding six months, he was using more and more oxygen (obviously he was hypoxic and needed it), and as long as he was not put in the hospital he got along pretty well. But his pulmonary disease was getting worse and worse and then he had oxygen rather continuously and it was turned up more and more. The only stimulant that his respiratory center is getting from his mild anoxia, which he is able to tolerate and live with, is being destroyed by giving him more oxygen, and consequently he goes into central nervous system depression and that is the end of it. Instead of relieving him you make him worse. So I think that this patient died from decompensated respiratory acidosis.

In summary then, Dr. von Haam, I think this man did have chronic pneumonitis with severe fibrosis, that he had severe pulmonary emphysema with bleb formation, and that he had asthmatic bronchitis. I put down cor pulmonale, which I think was not too great a problem if the record is correct. I can't help but put down carcinoma of the left lung with metastasis, with a question mark. The protocol is insufficient for me to come to that conclusion. I think he had some minor other disease associated with it leading to secondary anemia. I think his immediate cause of death was cerebral hypoxia due to pulmonary insufficiency, and oxygen intoxication which really means carbon dioxide narcosis.

Clinical Diagnosis

1. Pulmonary fibrosis with severe emphysema.
2. Chronic asthmatic bronchitis.
3. Cor pulmonale.
4. Carcinoma of the left lung (?).
5. Chronic duodenal ulcer.
6. Secondary anemia.
7. Oxygen intoxication.

Pathological Diagnosis

1. Pulmonary fibrosis with severe emphysema.
2. Subacute bronchitis.
3. Cor pulmonale.
4. Pulmonary hemorrhage, old and recent.
5. Gastrointestinal hemorrhage.
6. Secondary anemia.

Pathological Discussion

DR. VON HAAM: The body was well developed and well nourished. The heart was enlarged and universally dilated. The right ventricle measured 4 to 5 mm. in thickness. The lungs were quite heavy and filled with dark-red foamy edema. They were diffusely emphysematous with blebs scattered throughout the lung tissue. Both lung bases showed areas of nodular consolidation. There was no grossly demonstrable bronchiectasis. The stomach contained 500 cc. of coffee-ground material which came from numerous small bleeding spots. No ulcer was found. Tarry material was also present in the small bowel. The adrenals were extremely small and had a combined weight of only 11 grams. Permission was not obtained for autopsy of the brain.

Microscopic Examination

Sections through the lungs showed a very severe emphysema. Scattered throughout the emphysematous areas there was a diffuse and patchy pulmonary fibrosis. The small bronchioles appeared distended and filled with pus. With high magnification numerous unidentified dust particles could be noticed in the fibrotic areas. The dust was negative when tested for silica, beryllium or asbestos. There were only a few areas of acute pneumonic infiltration with few bacterial colonies. Special stains for fungi and tuberculosis bacilli were negative. Examination of the stomach and esophagus showed multiple hemorrhagic erosions but no evidence of peptic ulcer. Liver sections gave the picture of acute congestive failure with the formation of central lobular blood lakes and liver cell degeneration. The adrenal glands showed a remarkable cortical atrophy. The bone marrow showed a moderate degree of erythroid hyperplasia.

In summary, I feel that the patient had an obstructive type of emphysema caused by pulmonary fibrosis and chronic bronchitis. He also had evidence of acute adrenal insufficiency probably caused by the prolonged administration of cortisone. The heart changes can be explained by the combined effect of a chronic anemia and the increased resistance of the pulmonary circulation. I do agree with Dr. Forman that cerebral anoxia can produce all kinds of early neurological symptoms, and simple auricular fibrillation may give the clinical picture of a stroke. The point with regard to the oxygen intoxication is quite interesting. How do you think the oxygen hurt him and, how should this patient have been handled?

DR. FORMAN: Oxygen intoxication is being recognized more and more as a dangerous complication in this type of patient. If they receive it continuously, they will die from respiratory anesthesia. They do not tolerate continuous oxygen but must get it intermittently in order to prevent paralysis of the respiratory center. In cases of progressive pulmonary fibrosis it is important to prevent if possible any additional pulmonary infection, to keep the secretions from becoming too tough and tenacious, and to try to alleviate the great anxiety of these patients so that they can learn how to breathe better. It is very important to use as little oxygen as possible and to give it intermittently.

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Social Security Poll Results . . .

Members Totaling 4,095 Vote for Inclusion of Physicians; 2,737 Against; Ballots Mailed in by 76 Per Cent of State Association's Membership

IN a poll taken by mail during the month of October, 4,095 of the 8,960 members of the Ohio State Medical Association voted in favor of the inclusion of physicians in the Federal Social Security Program.

Members of the Association voting against the proposal, "Should Physicians Be Included in the Federal Social Security Program?," totalled 2,737.

Yes Vote 45.7% of Membership

Marked ballots were received from 6,832 members—76 per cent of the total membership of the Association. Fifteen unmarked ballots were received.

Those voting in the affirmative composed about 45.7 per cent of the total Association membership.

Up To Congress

Doctors of medicine are the only major self-employed group in the nation not covered under the Old Age and Survivors Insurance section of the Social Security Program. Proposals to remove that exemption have been before the U. S. Congress during the last several sessions of the Congress.

The Ohio State Medical Association poll was conducted as a result of a resolution adopted by the House of Delegates at the 1958 Annual Meeting in Cincinnati last April. The resolution read as follows:

Text of Resolution

WHEREAS, The inclusion of doctors of medicine in the Federal Social Security program is currently under consideration, and

WHEREAS, The Ohio State Medical Association and the American Medical Association are now on record as opposing the inclusion of physicians in the Social Security program, and

WHEREAS, A considerable number of physicians in Ohio have expressed a desire to be included in the Social Security program, and

WHEREAS, It is desirable to ascertain the current sentiment of all members of the Ohio State Medical Association on this question.

THEREFORE BE IT RESOLVED, That (1) the individual members of the Ohio State Medical Association be polled by the Association on the question as to whether they favor or oppose the inclusion of physicians in the Federal Social Security program, and (2) the results of this poll showing the number of votes in favor of and in opposition to such inclusion be made a matter of record and transmitted to the House of Delegates of the American Medical Association, and

BE IT FURTHER RESOLVED, That such poll be conducted prior to the 1958 interim session of the American Medical Association so that the results of such poll can be submitted to the House of Delegates of the American Medical Association at said meeting.

Ballots were sent to all members of record on October 1, 1958. Prior to that time many articles pro and con on the subject had been published in the July, August and September issues of *The Ohio State Medical Journal*. References to the poll were made on several occasions in the *OSMAgram* before the ballots were distributed.

Committee of Tellers

Counting of the ballots and tabulation of the results took place on November 5. A special committee had been appointed by Dr. George A. Woodhouse, President of the Association, for that assignment. It was composed of three Columbus members of the House of Delegates of the Association, namely, Dr. Robert M. Inglis, chairman, Dr. Perry R. Ayres and Dr. Philip B. Hardyman. Official announcement of the poll results was made by Dr. Woodhouse on November 7, following receipt of a report from Dr. Inglis.

Results of the Ohio poll will be transmitted to the House of Delegates of the American Medical Association by Ohio's delegates at the Minneapolis interim session of the AMA, December 2-5.

Present Policies

At present the official policies of the Ohio State Medical Association and the American Medical Association on inclusion of physicians in the OASI program, as established by their respective House of Delegates, are against the inclusion of physicians. In the past several years, resolutions which would rescind that policy and set up a policy in the affirmative have been introduced in both houses but have not been adopted.

Industrial Eye Problems

Industrial Eye Problems, a four day course in eye care and industrial eye programs will be presented by the Institute of Industrial Health and the Department of Ophthalmology of the University of Cincinnati on March 9-12, 1959. The course will be open to physicians only with preference given to men in active industrial practice.

Additional information may be had from the Secretary, Institute of Industrial Health, Kettering Laboratory, Eden and Bethesda Avenue, Cincinnati 19, Ohio.

APPLICATION FOR SPACE, SCIENTIFIC AND EDUCATIONAL EXHIBIT, OHIO STATE MEDICAL ASSOCIATION, 1959 ANNUAL MEETING, VETERANS MEMORIAL BUILDING, COLUMBUS, O., APRIL 21-24

1. Title of Exhibit: ____________________

2. Name(s) of Exhibitor(s): ____________________

____

Institution (if desired): ____________________

City ____________________

3. Description of Exhibit: **(Attach 200 word description to this blank)**

4. Exhibit will consist of the following: (Check which)

Charts and posters________ Photographs________ Drawings________ X-rays________

Specimens________ Moulages________ Other material____________________
(Describe)

5. Booth Requirements:

Length of back wall needed? ____________________

Square feet needed? ____________________

Shelf desired? (yes or no) ____________________

6. Transparency Cases:

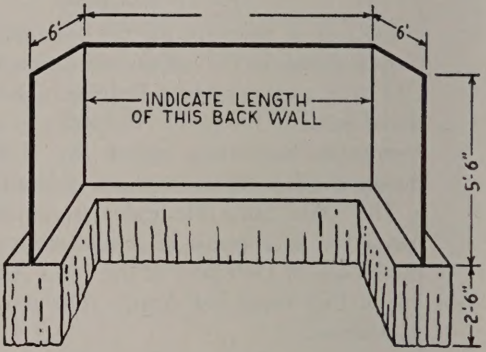
Needed? (yes or no) ____________________

If answer "yes," give following information:

Number of transparencies to be shown and size of each ________

____

____



Booths will have a back wall and two side walls. The side walls of all booths will be six feet wide. Back wall and side walls are eight feet high. If standard shelf is used, only 5½ ft. will be available for exhibit material. For most exhibits, a back wall, eight feet long will be sufficient. With the two 6 ft. long side walls, this gives a total of 110 square feet of wall space.

(It is suggested that transparencies should be no larger than 10 by 12 inches in order to conserve space. For size of view boxes which will be supplied by the Ohio State Medical Association if requested by you and how films should be mounted, see pages 3 and 4 of folder "Regulations and Information, Scientific and Educational Exhibit, Ohio State Medical Association.")

Date ____________________

____
Signature of Applicant

____
Mailing Address, Street

____
City, Zone, State

SEND APPLICATION TO: COMMITTEE ON SCIENTIFIC AND EDUCATIONAL EXHIBITS, OHIO STATE MEDICAL ASSOCIATION, 79 EAST STATE STREET, COLUMBUS 15, OHIO

Health Commissioners Act . . .

Score of Endorsements and Recommendations on State and Local Services Get the Approval of Commissioners at the Recent Conference in Columbus

OHIO'S health commissioners, at their 39th annual conference in Columbus on September 12, endorsed the Ohio State Medical Association's efforts to upgrade the performance of medical technology and evaluation of laboratories.

Addresses by OSMA President George A. Woodhouse and Dr. Ralph E. Dwork, state director of health, at the conference appear elsewhere in this issue of *The Journal.*

Other endorsements and recommendations voted by the health commissioners included the following:

Meat and Milk Proposal

A meat and milk hygiene program proposed by the Ohio State Veterinary Medicine Association; voluntary certification for sanitarians; licensing procedures and regulations for plumbers; placing of general health districts under civil service.

Continued study of the migrant labor problem in Ohio; minimum $20,000 a year salary for the state health director; legislation to provide for tuberculosis hospital conversion, financing and, if the situation merits, closure of such hospitals.

Funds To Be Asked

Classification of staphylococcal lesion occurring in the newborn period (first six weeks) as a reportable disease; appointment of a committee to study Ohio's school health laws for evaluation and recommendation at the 1959 conference; study of the problem of seeking additional legislative appropriation for expansion of the rheumatic fever program; legislative appropriation for training personnel to be used in health departments for providing increased and better services for infirmed aged.

Close adherence by local health departments to policies on vision conservation programs in schools recommended by the Vision Conservation Advisory Board to the Ohio Department of Health; provision of a copy of the recommended vision conservation program for all local health commissioners.

Back Air Pollution Control

Request that the State Health Department seek funds from the Legislature for implementation of an air pollution control program; establishment of a better industrial hygiene program in local areas; development of a plan for adequate and safe disposal of x-ray shoe-fitting machines; better liaison between the ODH's Nutrition Unit and the Ohio Department of Education in administrative supervision of school health programs.

Appointment of a committee to investigate and report back to the conference as to the responsibility of local health departments in the processing, distribution and safeguarding of food products; the expansion of the ODH Nutrition Unit's services as rapidly as possible.

Ohio Auxiliaries Getting Ready for 1959 AAPS Essay Contest

Local units of the Woman's Auxiliary to the Ohio State Medical Association are being asked again to sponsor the 1959 National Essay Contest of the Association of American Physicians and Surgeons. The contest has the approval of the House of Delegates of the Ohio State Medical Association which recommended that the auxiliaries sponsor the contest.

Entries in the contest may be written on either of the following subjects: "The Advantages of Private Medical Care" or "The Advantages of the American Free Enterprise System." The competition is open to all ninth, tenth, eleventh and twelfth grade students.

Last year over 300 essays were submitted from Ohio. In the National judging, Miss Jane Litzinger of Somerest, Ohio, received the eleventh prize, while Miss Janet Holshoy of Massillon, Ohio, placed thirteenth.

Dr. George H. Lemon, Toledo, is the Ohio essay chairman. He has sent essay information and package libraries to the presidents and secretaries as well as to the Public Relations Chairmen of all the local auxiliaries.

State prizes to be offered will be $100 for first place, $50 for second place, and $25 for third place. The winning state entries will be submitted for competition in the national judging. The national first prize is $1,000 with 13 additional prizes being offered.

Commenting on the contest, Dr. Lemon said: "This essay contest is important to every doctor and to all businessmen because it stimulates the high school children of this state and nation to investigate the values of private medical care and free enterprise. We urge every doctor to cooperate with the Woman's Auxiliary of his area to encourage the greatest participation possible."

Cooperation Essential . . .

OSMA President Calls for Physicians in Private Practice and Health Commissioners To Work Together Toward Solution of Mutual Problems

FOLLOWING is the text of the address of Dr. George A. Woodhouse, president of the Ohio State Medical Association, at the 39th Annual Conference of Ohio Health Commissioners with the Ohio Department of Health, in Columbus on last September 11.

* * *

It is a delightful experience for me to be invited to address your conference as a representative of the more than 9000 doctors of medicine who are members of the Ohio State Medical Association. I have been told that this is an annual occasion when the President of the Medical Association has the opportunity of making this address and thus the opportunity of further cementing the activities of our two organizations.

Objectives of OSMA

The first words printed in the Constitution and By-Laws of the Ohio State Medical Association are: "The purposes of this Association are to promote the science and art of medicine, and the protection of public health." Thus the founding fathers of organized medicine in Ohio realized over one hundred years ago the necessity of their participation in the affairs of public health. It still is one of our major objectives. The activities of both your department and the Ohio State Medical Association are cemented into one bulwark of defense in the matter of public health.

The control of the communicable diseases in the United States, and more particularly in Ohio, further connotes the activity of the two organizations. In 1900 the three leading causes of death, as an example, were all diseases of a communicable nature: pneumonia and influenza; tuberculosis; and diarrhea and enteritis. These three disease groups, with a combined death rate exceeding 500 per 100,000 population, accounted for nearly a third of all deaths. By 1956, with corresponding death rates per 100,000 of around 28, 9 and 5 respectively, the combined rate from these diseases had dropped to just over 40, or less than one-twentieth of all deaths. Mortality from most other communicable diseases had also been brought to exceedingly low levels and in some cases almost eliminated. It is particularly interesting to note in all the statistics presented to date the diminishing hazards of infancy, even with the tremendous rise of population; and while the population as a whole has benefited by the cooperative activities of public health officials and practicing physicians, the children and young adults have benefited the most in this mortality reduction.

Progress Brings New Problems

Continuing progress in medicine and public health will undoubtedly bring further reductions in mortality from pneumonia, influenza, and tuberculosis. Yet these diseases cannot be considered conquered as long as new cases are reported in large numbers. Progress itself brings new problems. For example, a rising proportion of tuberculosis patients are being treated with drugs, without long hospitalization; but these patients require careful medical and other supervision at home.

Against influenza, newly developed vaccines have had considerable effectiveness thus far. Much has been accomplished, especially in international cooperation in reporting new epidemics and in identifying the strain of the virus responsible. Nevertheless, effective control measures have not yet been evolved against all strains of the virus. Thus the further progress of public health activities is demonstrated in this air age of global responsibility.

The communicable diseases continue to represent a major challenge to medicine. The virus diseases especially, about which relatively little is yet known, bear special watching. Serious problems have been raised by the emergence of antibiotic-resistant strains of bacteria. Ultimately, however, the communicable diseases may become nothing more than an episode in man's history.

Role of Both Groups

I think that it might be well to discuss for a short period the role of the Public Health Official and that of the Practitioner of Medicine. In the application of public health, it takes one who treats the individual as a community and another who treats the community as an individual, to make progress in this field. The private practitioner has responsibilities in prevention, and consequently with mass disease and public health. The Public Health physician has a long line of responsibility in epidemiology and health education. He therefore wisely stays out of the field of individual treatment. Today the well-qualified public health leader must have medical training. In addition, he must be trained in group leadership, in administration, in handling of budgets, and in the application of educational measures to persuade the public to support actions beneficial to both individuals and whole communities.

Although some physicians and some medical societies have been charged with disinterest in public health, it is my belief that more and more of them are showing real concern for the well-being and betterment of their home towns. Certainly the success of public health programs depends to a large degree upon the practicing physicians, and other medical personnel and medical facilities in the community. A health department unsupported by the medical profession, divorced from the community hospitals and alienated from others in the community working towards the same goals, is indeed a sorry thing.

Should Get Together

I will admit that there have been times when the medical profession has been heard only when it criticised or opposed certain health programs which the profession believed to be unwise or impractical. However, the blame may not necessarily be on one side. It may be that the health officer went ahead on his own without adequate consultation. It may be that the medical profession was not kept informed of the reasons for the program and how it would operate. Regardless of who is to blame, the situation has been deplorable in that most differences have been unnecessary. We must eliminate rivalries and controversies which do immeasurable harm to our cause and bring public discredit upon both of us.

Fortunately, conditions such as I have described are few and far between here in Ohio. A spirit of cooperation between the Ohio State Medical Association and The Ohio Department of Health has existed for many years. I can't possibly name all who have had a part in this, but I would like to thank your present Health Director, Dr. Ralph Dwork, and his immediate predecessor Dr. John Porterfield for their help and cooperation. The Health Department has had problems, many of them major in nature. The Ohio State Medical Association has also had problems. How have these problems been approached? By cooperation and discussion around the table with our Council and committees.

Food For Thought

I have read with much interest the activities of the Ohio Department of Health in the magazine, *Ohio's Health,* May 1958 issue. The article, "Highlights of 1957," has given me and I am certain the other doctors of Ohio much food for thought. To myself it is amazing the work that has been done on a restricted budget, and I do know how much that budget was restricted. The heading of some of the articles tell an amazing story. Some of them are: "The Cost of Living," "Treatment Patterns are Changing," "Cases Harder To Find," "Staphylococcal Disease of The New Born," "Polio Continues Downward," "Asian Flu Appears," "Long Term Illnesses," "Diabetes and Rheumatic Fever," finally "Community Must Be Receptive," and many others. I congratulate you on your efforts.

New OSMA Activities

In conclusion, I would like to point out to the members of the Conference three new activities of the Ohio State Medical Association, authorized by the last session of our House of Delegates in Cincinnati. They are the formation of three new committees, namely, Committee on Care of the Aged, Traffic Safety Committee, and Poison Control Committee. Each of these committees is concerned with problems of Public Health in Ohio.

The Committee on Care of the Aged is a new one. It will study the problems of the aged and cooperate with similar work being done on a national level by the A. M. A., the American Hospital Association and other national groups, and with various State and local organizations and agencies, including Public Welfare and Public Health agencies. This is a long-term project which will require much work and cooperation.

The Traffic Safety Committee was formed after my suggestion that the rising number of deaths from highway accidents, together with the jamming of our hospitals with victims of such accidents, produce a problem which warrants the cooperation and study of a major committee of our organization. It is designed to implement the Traffic Safety program in Ohio being carried out by the Department of Highway Safety, the State Highway Patrol, and the Ohio Committee on Trauma of the College of Surgeons. This committee has had its first organization meeting, and is now functioning.

The Poison Control Committee will investigate the possibility of establishing a 24 hour-a-day single poison control center for all Ohio, or setting up area poison control centers in the state to help combat the rising tide of accidental poisonings from many brand name chemical products used in the home, on the farm and in industry. It has not been decided as to which plan would be most feasible. A statewide educational program, the study of possible state legislation for a uniform labeling of such products, and efforts to secure the cooperation of all organizations in the field of health and safety in developing a comprehensive statewide poison control program, will be undertaken by our committee.

Local Cooperation Essential

I have pointed out the cooperative spirit enjoyed by your State Director and his staff with the governing body and committees of the Ohio State Medical Association.

To you who are health officers of our counties and cities, I urgently recommend that you endeavor to build up the same kind of cooperation with your respective county medical society. Since cooperation is a two-way street, obviously, I strongly advocate that each of our county medical societies meet you at least half way.

I have been informed that in some counties, the local health officer, or officers, rarely attend a county medical society meeting.

On the other hand, I am advised that in some counties, it is difficult to get a physician willing to serve on the board of health, or to attend board meetings after he takes the assignment.

These situations must be corrected. If public health work in Ohio is to become really as effective as it should be, these conditions must be eliminated. It is time for the medical profession and the health officials in areas where these situations exist to draw up their chairs to the conference table and try to solve these, as well as other problems.

Again, Dr. Dwork and members of the conference, I wish to thank you for extending to me this opportunity to discuss some of our mutual problems. It is a gratifying relationship which I hope will continue indefinitely.

Today's Children Taller and Heavier Than Those of Last Generation

Today's children are taller and heavier than those of a generation ago.

Comparison of measurements for Michigan children made recently with those in 1937-1939 shows consistently higher figures for today's children. Among boys under 9, average heights were greater by a fraction of an inch, and at ages 9 and over by an inch or more. Among girls the difference was an inch as early as age 8. The increase in average weight ranged from more than 2 pounds at age 7 to as much as 13 pounds at age 14.

Similar trends for the average heights and weights of elementary school children are evident elsewhere in this country and in Great Britain and the Commonwealth countries.—*Metropolitan Life.*

Ohio Society of Internal Medicine To Coordinate Meeting with College of Physicians

The annual meeting of the Ohio Society of Internal Medicine will be held Wednesday, January 21, 1959, at 8 p. m. at the Netherland Hilton Hotel, Cincinnati. The presiding officers will be Dr. Arnoldus Goudsmit, Youngstown, president; Dr. Geo. J. Hamwi, Ohio State University, Columbus, vice-president; Dr. Leonard P. Caccamo, Associate of American College of Physicians, Youngstown, secretary-treasurer.

The annual meeting will be devoted to a review of the progress made by the Society in the interest of patient care requiring the specialty of internal medicine, in the State of Ohio during the year 1958. Plans for the activities for the coming year will be proposed and committee reports from a special liaison committee with Ohio Medical Indemnity, Inc. The membership will also be requested to consider a change of the by-laws of the organization. As has been the custom in the past, Dr. Arnoldus Goudsmit will deliver a presidential address.

A special feature included in the annual meeting this year will take place the following day in cooperation with the Ohio Regional Meeting of the American College of Physicians. Dr. A. Carlton Ernstene, governor of the College for Ohio, has invited the Ohio Society of Internal Medicine to take part in the program of the Regional Meeting. The Ohio Regional Meeting of the American College of Physicians will be held on Thursday, January 22, at the Veterans Administration Hospital in Cincinnati. The Ohio Society of Internal Medicine has that part of the program which starts at 4:20 p. m. and terminates at 5:30 p. m.

The special planning for this part of the program will be the presentation of a panel dealing with the subject matter "Status of the Internist in Medical Care Plans." Moderator of the panel will be Dr. Hamwi. The panel will consist of four members: Dr. William B. Walsh, Associate, American College of Physicians, and chairman of the Legislative Committee of the American Society of Internal Medicine, Washington, D. C.; Dr. John J. Grady, chairman of the Committee on Insurance Plans of the Cleveland Society of Internal Medicine, Cleveland; Mr. Charles H. Coghlan, executive vice-president of the Ohio Medical Indemnity, Inc., Columbus; Dr. Paul I. Robinson, coordinator of medical relations for the Metropolitan Life Insurance Company, representing the Health Insurance Council, New York, New York.

Health Director Reports . . .

Dr. Dwork Tells Health Commissioners Conference About the Major Department Activities and Problems at Recent Session in Columbus

At the recent 39th Annual Conference of Ohio Health Commissioners in Columbus, Dr. Ralph E. Dwork, Director, Ohio Department of Health, presented a detailed review of various activities and problems of the department. Following is an abstract of Dr. Dwork's talk.

* * *

For the state director this Conference provides a somewhat captive and certainly a most receptive audience. It is an opportunity for him to review the work of the State Department of Health, its problems, its hopes for the future; to comment on the work of local departments and cooperative ventures; to philosophize perhaps and even to dream a bit on the nature of public health and its growth.

Several things have occurred since our last meeting, in 1957, which have had an effect on our operational program both from an administrative and from a management viewpoint.

Although the fourth issue of the Financial Report of Local Health Departments indicates an increase in funds in most local areas, such was not the case in the State Department of Health.

Financial Problem

Late in February of this year, we were requested by the State Department of Finance to reduce our expenditures, insofar as state appropriations were concerned, by approximately $200,000 for the last three months of fiscal 1958. This was not easy.

For the three months of April, May and June we had to reduce planned expenditures within the Department itself by $67,000, and at the two tuberculosis hospitals, by $133,000. This meant, for example, that we did not open 27 of the planned 77 beds in the hospital at Nelsonville. In our hospital on the Ohio State University campus it called for consolidation of wards and eventual closing of 30 beds.

This same type of enforced restriction in expending funds appropriated to us by the Legislature is in effect during the present fiscal year and will continue at least until next June. For fiscal 1959 we have had to decrease the budgets of the two tuberculosis hospitals by $203,000 and the departmental budget by $100,000.

Cuts Made

These cuts, along with a decrease of about $65,000 in our tuberculosis grant-in-aid allocation and smaller reductions in other federal funds, made it necessary to reduce the cash grants of federal monies to qualified local health departments by approximately 20 per cent in fiscal 1959 as compared to fiscal 1958.

Analyzing our most recent publication depicting the financial situation in local health departments, on the other hand, we find that local appropriations for calendar 1958, excluding federal grants, is $12,508,184. This is a gain of almost $900,000 over 1957.

This anomaly of an increase in local funds, at the same time as a decrease is occurring in state funds, is partially explained by the recent mild recession, which we hope is about ended. State income is based largely on such sources as sales, gasoline and liquor taxes which are extremely sensitive to changes in consumer spending, whereas local revenues depend to a large extent on more stable sources such as taxes on real property.

It would be unfair not to point out that if consumer spending should drop again, eventually there would be an effect on local funds which might be reflected next year in smaller appropriations for local health departments. But as we said, there is hope that the recession is ended, that a leveling has occurred, even that an upturn has taken place.

Activities Curtailed

Because of the cuts in our funds, immediate steps had to be taken to cancel all existing vacancies and to fill only critical positions, as subsequent vacancies occurred. This, of course, has reduced our field program to some extent and limited the inauguration of some new programs we had planned.

We did, however, continue our program of allocating funds for special projects to local health departments in those activities particularly related to chronic diseases, rehabilitation and other phases of the aging problem. Last year we allocated about $60,000 for programs of this kind, and this year have increased it to about $90,000. These funds were specially earmarked in our federal general health grants. We expect to carry the special project allocation idea even farther in fiscal 1960.

Special Projects

Starting in July of next year, all funds available for field allocation from our federal Heart and Cancer grants will be assigned exclusively for conducting special projects. This, we hope, will be the future pattern, with more and more funds allocated on the basis of approved special projects until such time as all our funds for field distribution will be handled in this manner. At that time, assignment of federal funds to qualified local health departments on a formula basis will cease to exist.

I feel sure that you will agree with me that this approach to use of such funds ultimately will raise the level of health activity in the state, since we will be working on specific planned projects and not on overall generalized programs.

Another anomaly in the financial picture is a drop of two cents in the average per capita appropriation in local health districts, despite the total increase of nearly $900,000 which I previously mentioned. The average for this year is $1.35. The answer here is—increasing population. In full time departments, the per capita average for 1958 is $1.44; in part time departments, $.87.

In this connection, it is worth noting that nationally there are similar problems in trying to maintain a pace of growth in public health comparable to the growth in population. In a recent bulletin of the National Advisory Committee on Local Health Departments, it was noted that the ratio of health personnel to population was less favorable in 1957 than in 1950. . . .

Status of Local Departments

This is a good point to review the local health department status in Ohio. As of January 1, 1958, there were 132 local health units in the state. Sixty-nine of these are in the full time, qualified class, serving a total of 162 local health districts. Sixty-three part time, unqualified units serve another 72 local health districts.

This represents an elimination of four part time, unqualified units since last year, and the addition of seven qualified local health districts. It is worthy of note that there was a reduction of health units even though three new health districts were added during the year. Of the seven districts gaining qualified status, six were achieving it for the first time. One was regaining its former qualified status.

No area lost qualified status during the year. Approximately 84 per cent of the total population of Ohio now is served by full time qualified health departments.

Public Health levies were attempted by seven general health districts last fall. They were passed in only four, and three of those, were renewals.

Public Relations

In the past, the successful counties, so far as levies are concerned, have been those which have enlisted community participation, in the early planning of an educational program and campaign for the levy, usually with a local community group sponsoring the campaign.

Our Health Education Division has helped in the organization of such endeavors in a number of areas. The success stories have come definitely from those counties which planned early, secured key leadership from many segments of the population and worked hard on materials and methods of getting information to the general public.

The conception, development and maintenance of good public health programs call for a continually alerted, informed and interested citizenry. Where this exists, organization for support of tax levies, or for other types of support, is easier.

In this connection, let me make reference to use of the Health Services Report, the new document for reporting health department and other community health services, now in its third year.

We feel (and a number of you have said that you also feel) that the Health Services Report, when selectively applied, can be one of the best tools available to assist in the development of better community health services through joint agency program development and community planning. The full potential of this document is only beginning to be explored.

Turning now to the disease entities which have been of principal concern to us, we find that for a number of reasons tuberculosis has been demanding much of our time. Despite steady gains against it, it still is far from being under control. And actually, as the prevalence of tuberculosis continues to decline slowly, it becomes evident that we need more productive methods of case finding. X-raying on a mass basis is an expensive, low-yielding operation today without careful preselection of population groups to be x-rayed.

Use of the tuberculin test is getting a marked increase in interest these days. On a pilot basis we are now exploring use of the tuberculin test in tuberculosis control in two counties. Other tests are tentatively planned for the coming year. We are seeking the answers to many questions about both the use and limitations of the tuberculin testing method.

T. B. Bed Occupancy Problem

Perhaps the most important single development of major concern in tuberculosis control, since our last Health Commissioners' Conference, has been the bed occupancy problem. Occupancy averaged 70 per cent over the state as a whole as of July, 1957; it ranged from 43 to 92 per cent. This is a remarkable change from just a very few years ago when waiting lists were the universal rule.

While the relative importance of all the factors contributing to this problem are not completely understood, it is our best judgment that the most important single factor is the decreased length of hospital stay. This has resulted from the use of antimicrobial drugs and pulmonary surgery in tuberculosis therapy.

Decreased occupancy has quickly been reflected in increased per diem cost of hospital care. This and other considerations have caused boards of trustees and county commissioners to look critically at local situations and to consider partially or completely closing some sanitoria; or to consider converting either partially or completely to the care of other diseases.

State-Wide Study

Treating the problem on an individual local basis had seemed sufficient until recently. Toward the end of last year, it became apparent, however, that to avoid a disproportionate distribution of beds, the problem needed a state-wide view and long-range plan of attack. To this end, a meeting with medical directors of the sanitoria along with executive secretaries of Tuberculosis and Health Associations in the ownership counties was held in January of this year. A committee with representatives of the interested agencies was appointed to explore the problem in more detail. Later this month at another meeting of the original group, this committee is to present its preliminary findings.

There is a point in this which should be of special interest and concern to local health commissioners. More patients are being discharged in a rehabilitable state. They will require outpatient or clinic follow-up services for a longer period than formerly. The public health aspects of the care of tuberculosis, therefore, may be expected to put more than less demands on local health departments. In this aspect of the problem, we are in need of and will welcome consideration and advice from local health commissioners. This problem promises to be one of major administrative and medical importance for some time to come.

Status of State T. B. Hospitals

With respect to our own two tuberculosis hospitals on the campus of Ohio State University and at Nelsonville, I already have mentioned the effect of economies in limiting the number of available beds. I might report that the new recalcitrant unit in the Columbus facility, opened November 4, 1957, has admitted 32 patients to date. Of this number, five have been discharged. After periods of observation and indoctrination, most of these patients have been treated on open wards and have evidenced fairly good cooperation.

Along with the new problems in tuberculosis control, we still have the continuing problem of frequent ill-advised use of home therapy in active and usually infectious, illness. This procedure is dangerous to both patient and community, and all too often it has been condoned by local health departments.

Asian Flu

During the past year, our most dramatic experience was in dealing with the epidemic of Asian strain influenza, which gave us an unprecedented opportunity to work out with local health areas, a state-wide surveillance program involving in addition to morbidity and mortality reporting, the prompt communication of school and industrial absenteeism. Cooperation from local areas was excellent. Our ability to keep abreast of the situation on a state-wide basis exceeded our expectations.

The influenza outbreak in Ohio began during the early part of September and reached a peak in the latter part of October and early November. Cases continued to occur in early 1958, and an increase in incidence in March has been considered by some to have been a relatively minor second wave. No evidence has come to light which suggests that any substantial change in virulence of the organism occurred during the course of the epidemic. While morbidity was relatively high, and frequently the attack was over 50 per cent in given school populations, mortality was relatively low and remained so during the course of the outbreak.

In all, approximately 9,000 cases were reported, and 607 deaths were thought to be directly or indirectly the result of influenzal infection. The morbidity figure, of course, represents only a small fraction of total morbidity. The mortality figure likewise may be misleading. That the influenza virus was directly responsible for some deaths, however, has been confirmed by isolation of the Asian strain virus in the Ohio Department of Health Laboratory from postmortem specimens.

The influenza epidemic brought an onslaught of more than 2,000 specimens to the Laboratory. It gave a concrete example of what an epidemic can do to normal laboratory operation.

Planning for most advantageous use of vaccine, proceeded smoothly with admirable cooperation from all agencies involved. Due to the early onset of the epidemic it is certain that the vaccine played little or no control because of the small amount of the material available at the time. Vaccine effectiveness at a 50 to 80 per cent protection rate has been confirmed by control studies of the U. S. Public Health Service.

There is some possibility of an influenza outbreak during this coming winter. It is likely that the Ohio Department of Health will conduct surveillance programs patterned after the system used last year.

Staphylococcal Disease

Hospital-acquired staphylococcal disease has continued to be a major problem in infectious disease since our last meeting. Considerable progress has been made in investigation of the epidemiology of the disease, and its significance as a public health problem of national scope has been well delineated.

Precise methods of control within the hospital still are unknown and a vast amount of confusion exists in this area. One method of attack receiving almost universal acceptance, is establishment of intra-hospital infection committees. Such committees—comprised of members of the various medical services, nursing service, laboratory and administrative staff—have become a requisite for accreditation of general hospitals. Establishment by these committees of methods of communication within the hospital and systematic surveillance of infections is expected to be of value in early detection and subsequent control.

The importance of hospital-acquired infections as a hospital problem is now well recognized. Less well appreciated is the hazard that infected individuals present to the community after discharge. Organized public health has a responsibility in this area of threatened serious increase in community-acquired staphylococcal disease. The amount of time and effort that may be required, especially on the part of nursing staffs and laboratories, is tremendous. Obviously adequate means of communication between different hospitals, and between hospitals and health departments are essential. No blueprints of successful methods are available for this, and it falls on each of you to use local ingenuity in working out suitable communication procedures within each local jurisdiction. It is our feeling that the work of many local departments and our own department in this field during the past year has gone a long way toward improving hospital and health department relationships and should help to pave the way for continued productive work.

Polio

Through the first week in September 1958, 102 cases of poliomyelitis have been reported. This may be compared to the 163 cases which were reported through the same period in 1957 and to a mean number of 774 cases reported for the same period during the previous five years. Forty-two paralytic cases have been reported, 5 of which have been fully vaccinated. Four deaths due to poliomyelitis have been reported, all in unvaccinated individuals.

Interpretation of the steady decline in the incidence of poliomyelitis and its relationship to the widespread use of vaccine continues to be difficult, but the conclusion that vaccine has made a real impact on the disease is becoming more and more inescapable. The work of the local health departments in initiating and maintaining vaccination programs, often in the face of financial difficulties and sometimes frank opposition, is worthy and commendable. We regret that in the past year we have not been able to help materially with these programs. There still remains a substantial portion of the population without polio immunization and it is our intention to ask the next Legislature, as we did the last, for funds to assist local health departments in this valuable program.

At the last Conference, I mentioned to you the tremendous effort that was being made by several departments, especially in the southeast area, to combat a serious problem of endemic rabies among dog and wildlife population. During the past year these efforts have borne fruit and we have witnessed a dramatic decline in the incidence of canine rabies in several of the counties involved. We feel that it is fair to interpret the reduction as a result of control programs.

Laboratory Problems

Our Laboratory examined nearly 1,500 animal heads last year, in 251 of which evidence of rabies was detected. Studies on the extent and significance of rabies in bats is being continued. Evidence of rabies was found in a group of 35 bats from the Northeast section of the state. Recently the Laboratory received 45 bats from a southern section, but results on these are not yet available.

While we are talking about the Laboratory let me indicate that the Department is cooperating in national polio-surveillance studies, with the Laboratory providing direct support, as heretofore. Laboratory findings should provide important data on the value of Salk vaccine. Last year, as in the previous year, a wide variety of Coxsackie and ECHO viruses were isolated from cases of aseptic meningitis. The most prevalent of these in 1957 was ECHO 9. Again this year we have encountered a variety of viruses in aseptic meningitis.

Use of the Laboratory as an aid in diagnosis of viral diseases may be increased by the addition of new techniques. The Communicable Disease Center is helping by furnishing a variety of antigens and antisera not previously available. The poliomyelitis complement fixation test is one new procedure now available for use on paired sera. It is anticipated that practical serological tests for measles and Coxsackie infections may become available. The Laboratory is planning to explore uses of fluorescent antibody techniques as a means of rapid detection not only of viruses, but also of bacteria. Special studies involving newer respiratory disease viruses and virus-tumor relationships are in progress. The tissue culture laboratory has explored the use of five cell lines in the past year.

Leptospiral agglutination tests continue to detect cases of this infection in Ohio. The Laboratory Division recently added eight new strains as antigens in the testing program, and surveys of infection in the wild animal population were made in conjunction with the Veterinary Unit of the Division of Communicable Diseases.

Histoplasmosis and trichinosis are often important disease entities in this state. Our Laboratory has run over 500 blood specimens for histoplasmosis and 150 for trichinosis. Among unusual outbreaks discovered was one of histoplasmosis in eight quarry workers, and a hospital outbreak of trichinosis involving 70 persons.

Diabetes Screening

A new activity was added in the chemistry section of Laboratory, the examination of blood specimens for sugar in connection with diabetes screening.

At the last Health Commissioners' Conference, a detailed report on the diabetic screening project in Union County was presented. Since then very similar programs have been conducted in Jackson, Huron, Darke and Brown Counties, with about 9,000 persons tested. Results from all the tests are not yet available, but from 4,700 persons tested, 68 previously unknown diabetics were detected and referred to their private physicians. We plan to continue this work in the coming year, surveys having been arranged already for Greene and Preble Counties and others to be scheduled later. It is our firm belief that these programs represent sound public health endeavor. We commend those areas willing and able to participate in the pioneering of detection of non-infectious chronic disease. This certainly fits into the principal purpose of public health—to prevent occurrence of disease and disability.

Rheumatic Fever Program

There is continued high interest in the rheumatic fever prophylaxis program. Since the initiation of this program in April, 1957, a total of 3,352 persons have been enrolled in the program, with 82 of the 88 counties participating. From what we can determine, the program has been well accepted by the medical profession and greatly appreciated by participating families. The number of patients brought into the program is greater than we originally expected, and the cost too has been greater. Because of the potential value in the prevention of repeated attacks of rheumatic fever, we hope sincerely that this program will be continued. We hope no change will be necessary for the remainder of this fiscal year. I anticipate that it may be necessary to seek partial local support in this program by July, 1959. If this should be true, a thorough discussion of the problem and possible methods of local financing would be planned as far in advance as possible.

Mention might be made here of a new procedure in cardiac detection through screening of tuberculosis x-rays. Having the films re-read by a cardiac reader did not appear to be greatly productive in terms of detection of cases of heart disease which could be benefited by physician referral. This program, therefore, has been modified. In place of the re-reading, our tuberculosis readers now look more intently and specifically at the heart shadow and have increased their index of suspicions of abnormality. It is hoped that this compromise method will obliterate some of the problems of gross over-reading of possible defects, but at the same time provide useful information concerning probable or definite heart disease.

Hearing and Vision Programs

Something new also has been inaugurated in our hearing program, specifically, a team approach to differential diagnosis. In many previous otological diagnostic clinics, we had felt a need for a more comprehensive type of screening. There were children in whom we suspected other difficulties in addition to hearing defect, possibly mental or emotional block. Routing children to special facilities for additional examination at some distance was difficult. We decided to try an evaluation on a demonstration basis at a central location in the area being served. In this case, it was southeastern Ohio, and a Differential Diagnostic Clinic was set up at Nelsonville. This clinic, using a team approach, is staffed with specialists affiliated with or acceptable to Children's Hospital in Columbus (where the children otherwise would have been routed in this case.) In addition to the regular members of our Hearing and Vision Unit, the Clinic is staffed by an otologist, pediatrician, clinical audiologist, clinical speech pathologist and clinical psychologist. Only six to eight children are seen in a clinic day and each case is discussed in detail by the entire clinic staff. Comprehensive recommendations are made and forwarded to the referring physicians or agencies. Already a few children have been found who previously had been declared uneducable and were being kept at home but who would fulfill admission requirements of the State School for the Deaf or, in a few cases, the State School. The latter group, with I. Q.'s from 60 to 90 on first testing, stand a good chance for rehabilitation. In addition to filling a definite need, the Clinic is serving as a training facility for advanced students of Ohio University.

In this connection I should not fail to mention our new Hearing Cruiser. It was, as most of you know, specially built after extensive consultation. The Cruiser can be taken to any location where there is a source of electrical power and can be set up for testing within a short time. The arrangement of equipment will permit individual or group audiometer tests as well as more intricate methods of testing. It is attracting considerable national attention and we are proud that we have pioneered in its wider use.

New policies for vision conservation programs in schools have been drafted by an advisory board to the Department, in which somewhat greater emphasis is placed on early testing and case finding, preferably during the pre-school period. We hope that printed copies of these policies will be available for distribution during this meeting; or shortly thereafter.

Retarded Children

I think it would be worth a moment to talk about the Hamilton County Diagnostic Clinic for the mentally retarded. Four different agencies are involved in the project: the Ohio Department of Health, the Department of Mental Hygiene and Correction, Children's Hospital of Cincinnati, and the Hamilton County Diagnostic Clinic for the Mentally Retarded. The Clinic is staffed by a board pediatrician, a clinical psychologist, a psychiatric social worker, a pediatric nurse, and other highly trained professional persons on a full or part time basis. The Clinic will emphasize the need for early detection and the evaluation of the degree of retardation. It is our hope that it will be increasingly used as a training center.

Nurses Training

I should like to call your attention again to the extension courses being offered presently employed public health nurses at Ohio State University, Western Reserve, and University of Cincinnati. These courses call for only a half-day a week for a three to four month period and give college credit toward a B. S. degree. Approximately 200 nurses participated in these courses during the past year, and I want to congratulate those of you who made it possible.

It has been brought to my attention that there seems to be an increasing trend throughout the state toward the direct employment of nurses by voluntary health agencies for service in homes. This would only be happening because the public is wanting such service, and the voluntary agencies, being very sensitive to public wants, have been quick to step in. This is *your* problem on the local scene. Are you considering it? Is your own department failing to meet demands for home nursing services?

Are voluntary agencies in your area thinking of establishing separate nursing services? The choice is to a large extent in your hands, according to the action you take and your relationships in the community and with the voluntary agencies. By taking no action at all, you may wind up with a whole series of separate nursing services over which you have no control. You might be able to work out a combined service, partially supported by voluntary funds but operating under single public health direction. Or you may be able to satisfy the needs with expanded home nursing services from your department. Consideration of fees for some types of home service may come into this. It is my information that county welfare departments, for example, would be just as willing to pay health department nurses for home service as any other nurses. You might consider all these facts in determining your own course of action.

Nutrition Service

Also I should like to call your attention to the new "Ohio Diet Manual" produced by our Nutrition Service in cooperation with the Ohio Dietetic Association and other interested professional groups. It is a simplified manual suitable for use by cooks and food service supervisors in nursing homes and small hospitals which either cannot find or cannot afford professional dietitians. Physicians throughout the state repeatedly have mentioned the difficulty in obtaining suitable dietary modifications for patients in these smaller institutions. This new manual also will be a big help to public health nurses. And frankly, a number of health commissioners, themselves, have been using this manual to bring themselves up to date on diet therapy. The simplest way to get a copy is to get in touch with your district nutrition consultant.

The shortened period of hospital stay for tuberculosis patients brings another point of focus in need for nutrition education. Many of these patients have come to the hospital with established eating habits not conducive to good nutrition. They need guidance during their stay in the hospital and further help after returning home. A nutrition education program now is being conducted in 17 tuberculosis sanitoria. In nearly all of these, patients are given the opportunity and encouraged to attend the classes. Public health nurses in areas being served by these sanitoria are being oriented to the content of these classes and are developing plans for follow-up with patients' families.

The Fourth Ohio Conference on Human Nutrition, of which our Department was the principal sponsor, was highly successful this year, aimed particularly at school teachers and administrators, and had an attendance of more than 600. The next conference, tentatively scheduled for 1960, probably will be designed to meet the special needs of physicians and nurses on the staffs of local health departments. We shall welcome any suggestions you may have in this connection.

Industrial Hygiene

Turning to the field of industrial hygiene, it gives me pleasure to be able to state that a very effective attack has been made on the narrow concept that the industrial worker's health is for some reason unrelated to the total community. This attack was spearheaded by a series of Industrial Health Institutes arranged to indoctrinate the 1500 industrial nurses of our state in the principle that industrial health is an integral part of community health. It was apparent that many of these nurses not only welcomed but had been waiting for an invitation to become an important segment of the community health effort.

The philosophy that industry and the community are a whole and not separate entities is nowhere better illustrated than in the field of air pollution. For too long we have thought of air pollution as a mere technical problem. True, there are many technical problems to be solved, but none of these is quite so intriguing and profound as uniting the community and industry to achieve a single goal. Passage of Section 3701.041 of the Revised Code, effective September 7, 1957, relative to conducting atmosphere pollution research by the Department of Health and assisting sub-divisions in the abatement of pollution, makes clear that Ohio communities do want air pollution control. We believe that the abatement of air pollution can be accelerated by the united efforts of official health agencies, community associations and management groups. It is hoped that the Department will be able to help initiate a number of such cooperative efforts in the year to come.

Radiation Problems

Prevention of unnecessary ironizing radiation is another area in which the Division of Industrial Hygiene now is absorbed. This year, the State Public Health Council adopted a regulation banning the use of x-ray shoe-fitting machines except by physicians and chiropodists. This action is but an infinitesimal step in the total radiation problem in the state, however.

Do you know that Ohio now has three nuclear reactors operating or under construction, and that three more have been licensed for the state? As with air pollution there are difficult technical problems related to the safe operation of reactors. Yet these problems are presently surrounded by an uncertainty of the responsibilities to be assumed variously by the Atomic Energy Commission, U. S. Public Health Service, the Office of the Coordinator of Atomic Development Activities in Ohio, State Health Department and local authorities. We hope that in the year to come a clearer delineation of these responsibilities will be forthcoming.

Water Pollution Control

It probably has been impossible for you not to observe at least some of the progress being made in the state in the field of water pollution control. This is apparent now in virtually every part of the state in the rising construction of new municipal and industrial waste treatment facilities. As a matter of fact, the first five years of the new Water Pollution Control Board program has seen an actual doubling of the total capacity of municipal sewage treatment from approximately a half billion gallons a day in 1952 to more than a billion gallons a day now.

Three more cities and 14 new villages which lacked sewage treatment have placed treatment plants under construction since our last Conference. Another 10 municipalities, including two more cities, are to let contracts during the fall. We are very certain that these projects will be placed under construction quickly, because federal grants approved by our Department are contingent upon early construction.

Important waterworks improvements also were undertaken by 23 cities and 39 villages during the past year. Total valuation in plans reviewed by our Engineering Division for the year was more than $110,000,000. This included municipal and county water supply and purification facilities, sewerage and sewage treatment facilities, and industrial waste treatment.

Food Service Licensing

It is our feeling that Ohio's food service program is maintaining a high level of performance and satisfactory progress in the interest of safer food for public consumption. Food service programs of all city and county health departments were reviewed last year by the State Department. Measured against established criteria, 146 local health agencies were judged to be conducting satisfactory programs. Of 22 local programs deemed to be inadequate, only six were considered in serious difficulty.

Hospital Facilities

In the field of hospital facilities, we received an allocation of $4,493,652 for the fiscal year recently ended. To this was added $198,113 transferred to Ohio from Kentucky for assignment to the Goodwill Industries Rehabilitation Center project in Cincinnati. When completed this center will serve a number of border communities along the Ohio River in both states. Nineteen Hill-Burton projects have been approved in the approximate period since our last meeting. Twenty-one other projects are in the active planning stage and 10 in preliminary planning.

On the subject of buildings, . . . we are again asking the Legislature in its next session to consider funds for a separate State Department of Health Building. Many other state health departments do have their own buildings. I am sure that we could do a much better job if our divisions and units were together again.

We have many important going programs in which we must do everything we can to generate new incentive and drive; there are also many new programs just getting started, which are vitally needed, and for which we must contribute all the technical knowledge and experience that we have collectively, plus that added spark of ingenuity which often is the breath of life in gaining public support.

Arthritis To Be Postgraduate Subject at Northwestern

A postgraduate course in arthritis and related conditions will be given full-time on February 19, 20 and 21 at Thorne Hall, Northwestern University, Lake Shore Drive at Superior Street, Chicago. Tuition is $50. The faculty will be from all Chicago medical schools and will include six nationally known guest lecturers. Details may be obtained from Frank R. Schmid, M. D., 303 East Chicago Ave., Chicago 11, Ill., Secretary.

When To, When Not To, Perform Chest Fluoroscopies

The medical director of a large life insurance company recently asked the American College of Radiology about routine fluoroscopic examinations of the company's home office employees, as part of an annual physical examination. Crux of the medical director's query was whether this was a wise practice. The inquiry was referred to Dr. Richard H. Chamberlain, Philadelphia, Pa., chairman of the ACR Commission on Units, Standards and Protection. Excerpts from Dr. Chamberlain's personal opinion expressed to the insurance company medical director are presented below.

* * *

"I quite agree with you that there are proper indications for fluoroscopic examination of the heart and lungs in certain situations and that this should not be a cause of concern either to individuals or to their physicians, providing the reasons for such studies are adequate and the technique and apparatus used for it is of the modern type and with due attention to reduction of radiation exposure.

"With respect to the annual examinations of your employees, I think that one must exercise a different order of indication and that it is unlikely that a fluoroscopic examination is either suitable for or required as part of survey procedures for tuberculosis. In almost any instance, even several x-ray films would give tremendously less exposure and would actually give more detailed information. . . . I would like to call your attention particularly to [the College *Manual* on Protection] the practical section on chest fluoroscopy and also to the first section on "Other Procedures," which discusses the chest survey examinations. By comparing the values of exposure shown here, I think that it is obvious to you that chest fluoroscopy should be limited to situations with particular indications for the dynamics that are observable therewith.

"We are interested only in a fair and proper control of radiation exposure, veering neither too far towards the overly cautious side nor denying people the proper and excellent benefits derived from modern radiology. I am sure that this is also your attitude and anything that we can do together to forward this approach will be a mutually happy arrangement."—*American College of Radiology Newsletter.*

The average person today sees his doctor about five times a year, Health Information Foundation reports. In the aggregate, Americans use between 800 and 850 million physician visits a year.

WARNING TO ALL MEMBERS!

Your Memberships in the Ohio State Medical Association and American Medical Association, Including Subscriptions to *The Ohio State Medical Journal* and *The Journal of the AMA*, Will expire on December 31. Here's How To Renew Them:

It's time for all members to pay 1959 membership dues—local, state and national—unless in an exempt classification.

Mail your check immediately for dues to the SECRETARY-TREASURER of YOUR COUNTY MEDICAL SOCIETY.

OSMA dues are $25.00. AMA membership dues are $25.00. If you don't know the amount of your County Medical Society dues, check with your local Secretary-Treasurer.

Many members probably will want to send one check to cover local, state and national dues. Make Check Payable To Your County Medical Society. If you do tender a separate check for AMA dues, make it payable to your County Medical Society and mark on the check the words, "For 1959 AMA dues."

Your local Secretary-Treasurer will forward state and national dues for you and other members to the Columbus Office of the OSMA. That office will transmit AMA dues to Chicago.

Remember: As a part of the privileges and services offered to all members of the OSMA and the AMA, you will receive a year's subscription, without extra cost, to *The Ohio State Medical Journal* and *The Journal of the AMA* — or some other AMA publication of your own choosing.

Memberships and subscriptions are on a calendar year basis. Both expire on December 31. Renewal must be made by January 1, 1959, to keep them current.

Members who were exempt from paying OSMA or AMA dues, or both, in 1958 will be carried over automatically on the 1959 membership roster of both organizations unless their status has changed.

Tax Roundup for Physicians . . .

Here Are Pointers for Doctors and Summaries of State and Federal Tax Laws Under which Most Physicians Make Periodic Returns and Payments

DURING the early part of 1959 physicians will again face the task of filing returns and making payments under several categories of Federal, State and local tax laws. This article is presented for the purpose of furnishing at least basic information on the following taxes with which most Ohio physicians are confronted.

(1) Federal Income Tax Law, including payroll withholding on employees' salaries.

(2) Federal Social Security Tax including Old Age and Survivors' Insurance tax and the Federal and State Unemployment Insurance taxes.

(3) Ohio Personal Property Tax, including the tax on tangible property used in business and the tax on intangible personal property such as stocks, bonds, investments, cash and accounts receivable.

(4) Ohio Workmen's Compensation tax, required of those with three or more employees (optional for those with one or two).

(5) Ohio Sales and Use Tax.

(6) City Payroll Tax, applying to residents of cities which have such tax.

Information in this article is confined to those taxes on which the taxpayer or employer must file periodic returns. It does not include reviews of such taxes as those on real property, for which the taxpayer is billed directly, nor does it include discussion of many excise taxes for which the vendor of goods or services is primarily responsible; neither does it include a discussion of licenses.

The data and advice presented were obtained from authentic tax publications and from personal interviews with tax officials.

Nevertheless, physicains are advised to obtain supplemental advice and assistance in the preparation of their returns, from competent tax authorities or from staff members of the office of the District Directors of Internal Revenue or other appropriate agency. A tax expert may point the way to substantial savings as well as steer the taxpayer around embarrassing errors.

FEDERAL INCOME TAX

Taxpayers will pay 1958 Federal Income Taxes under provisions of the Revenue Code of 1954. Computation of this year's tax will be similar to that of the last three years since there have been no changes in the law.

Forms and Payments

Every person under 65 years old whose gross income for the year was $600 or more, and every person 65 years old or older whose gross income was $1,200 or more, must file certain income tax returns with the District Director of Internal Revenue for his district not later than April 15, 1959.

There are three types of returns, Form 1040A, Short-Form 1040 and Long-Form 1040.

Form 1040A may be used if the income was less than $10,000 and consisted entirely of wages reported on Withholding Statements, or such wages and not more than $200 total of other wages, interest and dividends (excluding $50 of dividends). When this form is used, if the income was under $5,000, the Internal Revenue Service will figure the tax and send the taxpayer a bill or refund. If the income was $5,000 or more, the taxpayer must compute his own tax.

Short-Form 1040 is used if the income is less than $10,000 and the taxpayer must include income from sources not eligible for reporting on Form 1040A; wishes to deduct from wages certain reimbursed expenses, travel, transportation, etc.; or the taxpayer wishes to deduct credits for dividends and retirement income.

Long-Form 1040 must be used if the income was $10,000 or more, or if the taxpayer wishes to claim nonbusiness deductions that amount to more than 10 per cent of income.

Income-Splitting

Many physicians will find it to their advantage to file joint returns with their wives, whether or not the spouse has income of her own. An unmarried person who qualifies as "head of household" may claim about one-half the tax benefit afforded a married couple on a joint return.

Declaration of Estimated Tax

The provisions for filing declarations of estimated income taxes are principally for those persons, a substantial part of whose income is not subject to withholdings.

When filing a final return for 1958, on or before April 15, 1959, most physicians will be required to file an estimate of 1959 income.

If income from items other than wages is $100 or less, declarations are required if the gross income from wages subject to withholdings can reasonably be expected to exceed $5,000 in the case of a single person; or $10,000 in the case of a married couple, head of a household or surviving spouse.

If income other than wages subject to withholdings can reasonably be expected to exceed $100 (excluding $50 from dividends), a declaration is required if total income including wages subject to withholdings can reasonably be expected to exceed $600 multiplied by the number of exemptions that could be claimed on the taxpayer's return, plus $400.

Times to file declarations of estimated tax by individuals is April 15 (or at time final return is made), June 15, September 15 and January 15. The date for filing an income tax return in lieu of a final declaration of estimated tax is January 31. Thus, if an income tax return is not filed before February 1, the last day for filing declaration or an amended declaration is January 15.

If the estimated tax paid is 70 per cent or more of the actual tax liability, no penalty is assessed. For physicians who find it difficult to estimate their income in advance, it is suggested that they use the previous year's income as a basis and later file an amended declaration if the situation changes considerably.

Physicians in Private Practice

To summarize, most physicians in private practice must comply with the following procedures:

1. On or before January 15, 1959, make a fourth quarter return on declaration of estimated income for 1958.
2. On or before April 15, file a complete income tax return for 1958.
3. Pay the difference, if any, between the income tax paid quarterly and the amount of tax liability shown on the final return. If he has overpaid, the excess will be refunded or credited against future payments.
4. On or before April 15, file a declaration of estimated tax liability for 1959, and pay either the full amount or one-fourth of it. If he elects to pay quarterly, the remaining final dates for payment are June 15, September 15 (and January 15, 1960).

Adjusted Gross Income

Individuals who are employed and receive a salary have little difficulty in arriving at the amount of their adjusted gross income. The total salary received plus amounts received from interest, dividends, rent, or from other sources, would in such cases constitute the gross adjusted income.

The physician in private practice has more difficulty in arriving at his adjusted gross income than the person on salary. From the amount of his cash receipts—if he reports income on the basis of cash received and dibursements, or on the amount of total charges if he uses accrual method of reporting his income—he may deduct all items of expenditure necessary in earning his income. These items are described in more detail in the following sections:

Deductible Business Expenses

Office Rental—If a physician pays rent to another person for office space, he may deduct such amount. If he rents a combined home and office, he may deduct that portion of the rent charged for the office. If he owns his own home and maintains an office in it, he **cannot** claim deduction for office rent. However, he is entitled to claim depreciation on that portion of the property occupied as an office, and the proportion of operating expenses chargeable to the office.

Automobile—The cost of repair and upkeep of an automobile, including gasoline and oil, used in professional visits may be deducted. That part of the salary paid to a chauffeur and attributable to time spent in driving his employer on professional calls, may be deducted. Sums spent for taxi hire, bus fare, etc., while on professional calls, may be deducted.

Depreciation may be deducted on an automobile used in professional business. The depreciation which should be deducted annually is determined by dividing the cost price of the machine, less salvage value, by the number of years of its usefulness. Salvage value is the estimated amount that will be realized upon sale or disposition of the automobile at the end of its useful life—the useful life varying according to the policy of the taxpayer.

If a physician has one automobile which is used exclusively in professional business, he may deduct the full depreciation each year. If the machine is used only partly in professional business, the deductible depreciation should be computed on the basis of the number of miles the car is driven for professional purposes. If a physician possesses two cars, each of which is used partly in professional business the deductible depreciation on each car should be computed on the basis of the number of miles each car is driven for professional purposes.

The physician should seek the advice of a tax expert as to whether or not application of the "declining-balance method" (explained in the instructions which accompany the tax forms) would be advantageous to him.

A loss occasioned by damage to an automobile maintained either for business or pleasure, which is not due to the willful act or negligence of the taxpayer, is deductible loss in the computation of net income, provided the taxpayer has not been reimbursed for such loss by insurance.

It is suggested that physicians be prepared to substantiate claims for deductions from gross income for professional use of automobiles in case income tax officials should call on them for written records to show the mileage traveled by them in connection with professional practice, or to prove just what part of their automobile maintenance expense was a professional expense, and therefore deductible.

Professional Dues—Dues paid to professional associations to which, in the interest of his profession, the physician belongs, may be deducted.

Refresher Courses—The Internal Revenue Service makes a distinction between expenses for advanced education and those for refresher courses (Sec. 1.162-5 of the Internal Revenue Service regulations).

The regulation provides that expenditures for education are deductible if they are for "refresher" or similar types of courses taken to maintain the skills directly and immediately required by the physician in his employment or practice. An educational course to be covered should be designed for established medical practitioners to help them keep abreast of current developments in the profession; it should be of short duration; it should not be taken on a continuing basis, and should not carry academic credit.

Cost of education designed to prepare the practitioner to enter a specialty is not deductible.

Travel Expenses—When a physician travels away from home primarily to obtain "refresher" education or to attend a medical convention for professional purposes, his expenditures for travel, meals, lodging, etc., are deductible. However, expenses for personal activities such as sight-seeing, social visiting, personal entertaining or other recreation, are not deductible. A physician who is accompanied by his wife to a medical convention may deduct the amount that the trip would have cost him alone. For example, if he and his wife have a double room, he may deduct the amount that he would have paid for a single room.

Salaries and Wages—Deductions are permitted for the salaries or wages of nurses, laboratory workers, technicians, assistants, stenographers, or other clerical workers in a physician's office so long as their duties are connected with professional work; also for wages paid maids, janitors, etc., for services rendered in connection with professional practice.

Medicine, Supplies, Etc.—Cost of medicines used in the office to treat patients, medicine dispensed, bandages, laboratory materials, chemicals and other supplies "consumed in the using" and necessary to operate the office may be deducted.

Depreciation—Depreciation may be claimed on instruments, laboratory equipment, office furniture, books, etc., of more or less permanent value, the rate of depreciation depending on the estimated useful life of the article. The "declining-balance" method of depreciation permits the taxpayer to charge off a larger proportion of the cost of equipment during its early life, under certain conditions.

If improvement to offset obsolescence and wear and tear or injury has been made and deduction for the cost claimed elsewhere in the return, claim should not be made for depreciation.

Uniforms—The Internal Revenue Service permits deduction of the cost of medical uniforms (garments, etc., necessary in practice but not suitable for street wear) as business expense.

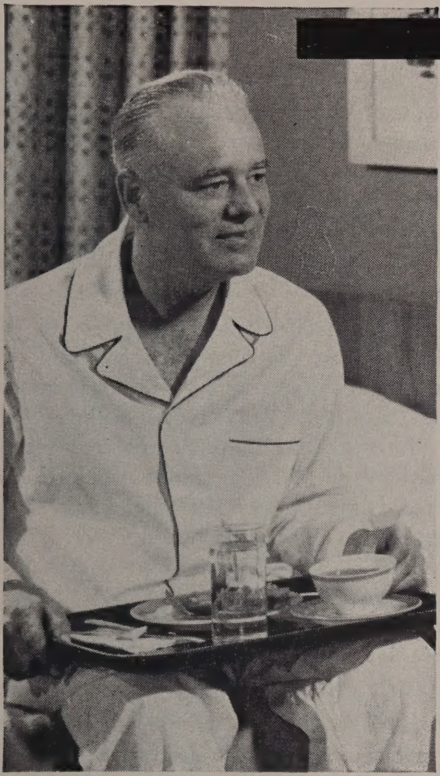
General Office Expenses—The cost of telephone, telegrams, heat, light, water, etc., used in professional services is deductible. Physicians who keep current magazines and newspapers in their waiting rooms for the benefit of their patients, may deduct this item as a business expense. The cost of professional journals for the physician's own use is also a deductible item.

Debts—If the physician's books are kept according to the "Cash Receipts and Disbursements" system, he may not charge off any unpaid debt because he is then only reporting as gross income those accounts which have proved to be good. Bad accounts have not been reported and are therefore not deductible.

If books are kept on an "Accrual Basis" (i. e., all fees, either cash or account are included in income reported for tax purpose) it is permissible to charge off all debts which have been definitely ascertained to be worthless during the fiscal year covered by the report.

The physician using the latter system must be careful to include in gross income bad debts which have been charged off in previous years but collected during the calendar year for which the return is filed.

Taxes and Licenses—State and county taxes, except those assessed against local benefits of a kind tending to increase the value of the property assessed and those imposed upon the taxpayer



IN DEBILITATING DISEASE

Patients receiving

NILEVAR®

Eat more...
Feel better...
Recover faster

Compared to control patients, those receiving Nilevar (brand of norethandrolone) have repeatedly demonstrated more rapid and more complete recovery from serious acute illness and increased comfort and well-being in chronic illness.

A multitude of case histories are now adding individual clinical color to the earlier controlled investigations which defined the actions of Nilevar as an effective aid in reversing negative nitrogen balance and in building protein tissue.

In typical case reports such gratifying comments as these appear:

Underweight —"Appetite considerably increased within one week. Sense of well-being and vigor increased along with increased appetite."

Prematurity (Birth weight: 2 pounds, 4 ounces) — "Gradual improvement in appetite and capacity for formula. . . . Excellent progress and weight gain for a very immature infant."

Carcinoma of the Uterus —"Within four days appetite became excellent, took full diet. . . . More ambition while on Nilevar. Enjoys life. Takes part in church and other social affairs."

Third Degree Burn —". . . soon began eating all that was offered. . . . Began to show signs of hope for recovery. . . . Perhaps one of the greatest changes was in the appearance of his wounds which were so very much improved."

The dosage for adults is 20 to 30 mg. daily in single courses no longer than three months. For children the daily dosage is 0.5 mg. per kilogram of body weight, in single courses no longer than three months.

Nilevar is supplied in tablets of 10 mg. and ampuls of 25 mg. (1 cc.).

G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

SEARLE

upon his interest as shareholder of a corporation which are paid by the corporation without reimbursement from the taxpayer, are deductible. Taxes on one's own home are not to be considered as business expenses, such taxes being allowable as nonbusiness deductions only.

Fees and expenses paid for "securing the right to practice" are not deductible, such as the fee paid to secure a license from the State Medical Board. Other license fees which the physician must pay, including narcotics registration and local occupational taxes, are deductible. The cost of an automobile license, unless the car is used exclusively for business, is to be taken as a nonbusiness deduction only. The tax paid on telephone bills if the telephone is used for business only, is deductible as a business expense. This would apply to office phones. The tax paid on other telephone bills is not deductible. Federal taxes on amusements, club dues, furs and luxuries are also not deductible for Federal income tax purposes.

Federal Old Age Benefits and Unemployment Compensation Taxes paid by employers under the Social Security Act are proper deductions in making income tax returns. Such taxes are deductible in returns for the taxable year in which they are accrued or paid, depending upon the method of accounting employed by the taxpayer. Social Security taxes withheld by an employer are not deductible by the employee in computing his tax liability.

Insurance Premiums—Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries to a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment and damage to or loss of professional equipment by fire or otherwise. Premiums paid on life insurance are not deductible.

The United States Tax Court in a case decided in June, 1957, held that premiums paid by a doctor for disability insurance **are non-deductible** personal expenses, even where the policy is called a "Professional Income Policy." In the case before the court, there were no provisions in the insurance policies specifying that payments thereunder during disability were to defray or reimburse the holder for business or overhead expenses. Specific provision must be set forth in any policies of this type that the amounts will be for business or overhead expense in order to make the premiums deductible.

Sales Tax Payments—The sales tax paid in connection with purchase of items used in business become a part of the cost thereof and as such are deductible as business expenses. Other amounts expended for sales tax are nonbusiness deductions and not to be taken as business expenses.

Ohio and Federal Gasoline Taxes—There is a five cents per gallon Ohio tax on gasoline, and a three cents per gallon Federal tax. These amounts are deductible. However, if a physician has already included overall cost of gasoline as part of his business expenses, the tax is not again deductible. The Ohio 5 cents tax paid on gasoline not used in business is deductible as a nonbusiness deduction. The Federal tax is deductible only as a business expense.

Interest—Amounts paid as interest on business indebtedness may be taken as business expenses. Interest items paid on personal indebtedness are deductible only as nonbusiness deductions. Interest paid to carry tax free securities may not be deducted. The interest deduction may not exceed the portion of the total carrying charges attributable to the taxable year.

Carrying charges on installment purchases up to 6 per cent of unpaid balances are deductible where the taxpayer has carrying charge separately stated in installment sales contract.

Losses by Fire and Theft—Loss or damage to a physician's equipment by fire, theft, or other cause, not compensable by insurance or otherwise recoverable, may be computed as a business expense, and is deductible, provided evidence of such loss or damage can be produced. Such loss or damage is deductible, however, only to the extent to which it has not been made good by repair, and the cost of the repair is claimed as a deduction.

Legal Expenses—Expense incurred in the defense of a suit for alleged malpractice is deductible as business expense. However, expense incurred in the defense of a criminal action is not deductible. The cost of contesting tax liabilities is deductible.

Entertainment Expenses

Following are excerpts from a communication sent to a medical society in Mississippi by a District Director of Internal Revenue which the Law Department of the AMA says was one of the best explanations regarding deduction of physician's entertainment expenses it has seen:

1. A physician may deduct on his federal income tax return the costs of entertainment, provided he can establish to the satisfaction of the Internal Revenue Service, by appropriate evidence, that such expenses are ordinary and necessary business expenses and clearly related to the production of business income.

2. The amount of the deduction must be proved

and its reasonableness determined. Once the amount is established, the deduction may be claimed when the doctor is able to show that the entertainment had a direct relationship to the conduct of his practice and can show the business benefit reasonably to be expected from the expenditure. The general statement that he hoped or expected to get referrals or patients as a result of the entertainments is not enough. If personal reasons predominate, the expenditure may not be deducted, even though there is some possibility of a business benefit. Except in the case of industrial physicians, entertainment of individuals who are not doctors will not ordinarily qualify because the possibility of benefits to be expected is so remote as to be negligible. In instances of the entertainment of patients, the same general rules apply as in the entertainment of other doctors, and the clear relationship of the expenditure to reasonably expected income must be shown. The same rules also apply to civic and other club dues.

Criteria to be used in establishing the deductibility of entertainment expenses include, but are not limited to, the following:

a. Specific purpose of entertainment. b. Nature of the practice of the doctor incurring the expenditure. c. Period of time the doctor has been in practice and the number of patients he already has. d. Percentage of his patients received as referrals. e. Names of individuals entertained and reason why additional income could reasonably be expected from each. f. Whether or not referrals were actually received from the doctors entertained and any indication of the effect of the entertainment on these referrals. g. Number of times individual doctors were entertained during the year, inasmuch as repeated entertainment indicates a personal motive. h. Whether or not other doctors in the same type practice in the locality have entertainment expenses.

Exemptions and Allowances

An exemption of $600 may be claimed by the taxpayer for himself. He may also claim an exemption of $600 for each dependent of close relationship, or for certain other dependents living in his household. To claim an exemption for a dependent, the taxpayer must have furnished over half of the actual amount used for the dependent's support in the taxable year. Scholarships do not count as income to the child in determining the extent of parental support.

Exemption also is contingent upon the dependent, other than a child, having a net income of less than $600 for the year. A child may earn $600 or more and still qualify as a dependent if he is under 19 or a full-time student for five months during the year, or taking on-the-farm training, provided the taxpayer contributes more than half of his support.

An additional personal exemption of $600 may be claimed by the taxpayer if he is over 65, another if he is blind; another if his spouse is blind; and still another if the spouse has reached the age of 65. (These provisions do not apply to dependents other than spouse.)

Nonbusiness Deductions

Regardless of whether or not the taxpayer claims business expenses, he may claim the following deductions if eligible to do so, **providing that there is not a duplication of deductions under the two categories.**

Contributions, Gifts, etc.—The individual taxpayer may deduct contributions up to 30 per cent of adjusted gross income, if the last 10 per cent is given to a church, an association of churches, an educational institution or a hospital. The ceiling remains at 20 per cent for contributions to other charitable organizations, no substantial part of the activities of which are carrying on propaganda or otherwise attempting to influence legislation.

Medical and Dental Expenses—The taxpayer may deduct medical and dental expenses which exceed 3 per cent of the adjusted gross income. However, in figuring these expenses, the amount paid for medicine and drugs may be taken into account only to the extent it exceeds 1 per cent of the adjusted gross income.

The deduction may not exceed $2,500 multiplied by the number of exemptions other than the exemptions for age and blindness. In addition there are maximum limitations as follows: (a) $5,000 if the taxpayer is single and not a head of household or a qualifying surviving widow or widower; (b) $5,000 if the taxpayer is married but files a separate return; or (c) $10,000 if the taxpayer files a joint return, or is a head of household or a qualifying surviving widow or widower.

If the taxpayer or his wife is 65 or over, the maximum limitations are the same as in the foregoing paragraph. However, amounts deductible for medical and dental expenses are not restricted to the excess over 3 per cent of adjusted gross income. In effect, the 3 per cent rule may be disregarded. But the amounts spent for medicine and drugs are still limited to the excess of 1 per cent of income, and amounts spent for dependents' medical expenses are deductible only to the extent they exceed 3 per cent of adjusted gross income.

Medical expenses paid by an estate within one

(Continued on Page 1636)

"Much better–
thank you, doctor"

Proven in research

1. Highest tetracycline serum levels
2. Most consistently elevated serum levels
3. Safe, physiologic potentiation (with a natural human metabolite)

And now in practice

4. More rapid clinical response
5. Unexcelled toleration

COSA-TETRACYN*

GLUCOSAMINE-POTENTIATED TETRACYCLINE

CAPSULES
(black and white)
250 mg., 125 mg.
(for pediatric or long-term therapy)

ORAL SUSPENSION
(orange-flavored)
125 mg. per tsp. (5 cc.)
2 oz. bottle

NEW! PEDIATRIC DROPS
(orange-flavored) 5 mg. per drop, calibrated dropper,
10 cc. bottle

COSA-TETRASTATIN*

glucosamine-potentiated tetracycline with nystatin

Antibacterial plus added protection against monilial super-infection

CAPSULES (black and pink) 250 mg. Cosa-Tetracyn (with 250,000 u. nystatin)

ORAL SUSPENSION 125 mg. per tsp. (5 cc.) Cosa-Tetracyn (with 125,000 u. nystatin), 2 oz. bottle

COSA-TETRACYDIN*

glucosamine-potentiated tetracycline-analgesic-antihistamine compound

For relief of symptoms and malaise of the common cold and prevention of secondary complications

CAPSULES (black and orange)—each capsule contains: Cosa-Tetracyn 125 mg.; phenacetin 120 mg.; caffeine 30 mg.; salicylamide 150 mg.; buclizine HCl 15 mg.

REFERENCES: 1. Carlozzi, M.: Antibiotic Med. & Clin. Therapy 5:146 (Feb.) 1958. 2. Welch, H.; Wright, W. W., and Staffa, A. W.: Antibiotic Med. & Clin. Therapy 5:52 (Jan.) 1958. 3. Marlow, A. A., and Bartlett, G. R.: Glucosamine and leukemia, Proc. Soc. Exp. Biol. & Med. 84:41, 1953. 4. Shalowitz, M.: Clin. Rev. 1:25 (April) 1958. 5. Nathan, L. A.: Arch. Pediat. 75:251 (June) 1958. 6. Cornbleet, T.; Chesrow, E., and Barsky, S.: Antibiotic Med. & Clin. Therapy 5:328 (May) 1958. 7. Stone, M. L.; Sedlis, A., Bamford, J., and Bradley, W.: Antibiotic Med. & Clin. Therapy 5:322 (May) 1958. 8. Harris, H.: Clin. Rev. 1:15 (July) 1958.

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PFIZER LABORATORIES *Division, Chas. Pfizer & Co., Inc., Brooklyn 6, New York* year after death are considered paid by the decedent.

The term "medical care" is broadly defined to include "amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body (including amounts paid for accident or health insurances)."

In regard to payment of premiums on accident and health insurance, the Internal Revenue Service has ruled that premiums may be deducted for insurance that provides for indemnity for the cost of medical care and specific injury, but may not be deducted for insurance which indemnifies the holder solely for the loss of earnings.

In order to obtain this credit for medical and dental expenses, the taxpayer is required to list the name and address of the person to whom the payment is made, the approximate date of actual payment and amount. It should be noted that this will furnish the Internal Revenue Service with data which can be used in checking returns filed by physicians and dentists—another reason why they should keep accurate records and compile their returns carefully.

Interest—The taxpayer may deduct interest on a personal note to a bank or individual, a mortgage on his home, a life insurance loan if the interest is paid in cash, or interest on delinquent taxes.

Taxes—Deduction may be made for taxes paid on personal property or real estate, for city income taxes, retail sales taxes, auto license fees, state gasoline taxes.

Casualty Losses and Thefts—The taxpayer may deduct losses due to destruction of property by fire, stolen property or cash, and storm damage, if not claimed as a business deduction and not covered by insurance.

Optional Standard Deduction

The optional standard deduction permitted in lieu of listing amounts paid for contributions, interest, taxes, and other nonbusiness deductions is 10 per cent of the adjusted gross income, but not in excess of $1,000; or $500 in the case of a married person filing a separate return.

Partnerships

The partnership itself is not subject to income tax, but is required to file an information return. The tax liability falls upon the individual partners. Partnerships may be simple agreements by which two or more physicians share expenses and prorate income. On the other hand, they may be elaborate entities. Since there are many special regulations pertaining to partnerships, partners would do well to seek expert advice.

Retirement Income

Retirement income, including pensions, annuities, interest, rents, dividends, etc., are subject to special treatment under the income tax laws.

District Offices and Districts

Income tax payments and returns must be made at or mailed to the office of the District Director of Internal Revenue for the district in which the taxpayer has his legal residence. There are four internal revenue districts in Ohio. The counties comprising each district follow:

For the Columbus District (Ohio 11th) Director of Internal Revenue, 110 W. Long St., Columbus; comprising the following counties:

Adams, Athens, Coshocton, Delaware, Fairfield, Franklin, Gallia, Guernsey, Hocking, Jackson, Knox, Lawrence, Licking, Madison, Marion, Meigs, Morgan, Morrow, Muskingum, Noble, Perry, Pickaway, Pike, Ross, Scioto, Union, Vinton and Washington.

For the Cleveland District (Ohio 18th) Director of Internal Revenue, 626 Huron Rd., Cleveland; comprising the following counties:

Ashland, Ashtabula, Belmont, Carroll, Columbiana, Cuyahoga, Geauga, Harrison, Holmes, Jefferson, Lake, Lorain, Mahoning, Medina, Monroe, Portage, Richland, Stark, Summit, Trumbull, Tuscarawas and Wayne.

For the Cincinnati District (Ohio 1st) Director of Internal Revenue, Post Office Building, Cincinnati; comprising the following counties:

Brown, Butler, Clark, Clermont, Clinton, Fayette, Greene, Hamilton, Highland, Miami, Montgomery, Preble and Warren.

For the Toledo District (Ohio 10th) Director of Internal Revenue, Toledo; comprising the following counties:

Allen, Auglaize, Champaign, Crawford, Drake, Defiance, Erie, Fulton, Hancock, Hardin, Henry, Huron, Logan, Lucas, Mercer, Ottawa, Paulding, Putnam, Sandusky, Seneca, Shelby, Van Wert, Williams, Wood and Wyandot.

INCOME TAX WITHHOLDINGS

Every employer who pays wages to one or more employees, where an employer-employee relationship exists, must withhold from such wages and pay over to the Federal Government periodically an amount prescribed by law.

The amount to be deducted from each pay check may be determined by referring to the *Employer's Tax Guide Circular E* after having the employee fill out Form W-4 to determine the number of exemptions he claims. The handbook is supplied by the District Office of the Director of Internal Revenue.

The amount deducted is paid to the District Office of the Director of Internal Revenue together with report on Form 941, quarterly during the month immediately following the quarter for which deductions are made. (Social Security taxes are reported on this same form.)

The employer is required to give each employee from whose wages he has withheld income tax during the year a statement in duplicate showing the amount of tax withheld and wages paid for that year. Forms W-2 in quadruplicate are supplied for this purpose. The original copy of Form W-2 is to be filed with the Employer's Quarterly Federal Tax Return, Form 941, for the last quarter. The second and third copies are furnished the employee and the fourth copy retained by the employer for his records. Statements must be furnished employees and reports made to the government between January 1 and January 31, for the previous year.

Deposit of Withholdings

An employer who withholds as much as $100 per month for the purposes of income tax liability and F. I. C. A. liability (employer's and employee's shares) shall take these funds with Form 450 to a bank and deposit them. The bank transmits this form to the Federal Reserve Bank in Cleveland for validation, after which it is returned directly to the employer. The depositary receipt, Form 450, is then eligible for use.

Report of Funds Paid

As in previous years, payments in excess of $600 made during the year for interest, rents, or commissions, not subject to withholdings and paid to anyone other than a corporation, must be reported on Form 1099 and transmitted with Form 1096, on or before February 15 of the following year to the Director of Internal Revenue, Processing Division, Kansas City, Mo.

SOCIAL SECURITY TAXES

The Federal Social Security Act embodies laws pertaining to Old Age and Survivors' Insurance and Unemployment Insurance. Because the procedures for paying these taxes are different, they are discussed here under separate headings.

A person 65 years old or older who is receiving Social Security benefits may now earn up to $1,200 a year without losing his benefit. For any excess earnings over $1,200 he may lose one month's benefits for each $80 or fraction thereof. A person 72 or older may earn any amount and continue to draw benefits.

Favored Tax Status of Associated Members Has Limitations

Under current rules, the Internal Revenue Service, is not denying to unincorporated associations of doctors favored tax status in regard to pension plans for members. The effect is that members of such associations enjoy approximately the same annuity advantages they would under the Jenkins-Keogh and similar bills now pending in Congress.

Those planning to take advantage of this favored tax status must be careful not to put themselves in jeopardy under the Ohio law prohibiting the corporate practice of medicine.

Not covered for social security purposes are services performed by an individual in the employ of his son, daughter, or spouse, and services performed by a child under 21 in the employ of his father or mother.

Under provisions for coverage of self-employed workers, physicians are specifically excluded.

Domestic workers in private homes who receive wages of at least $50 in a quarter are covered. In other words, if a taxpayer has a cleaning woman, or other domestic worker, only one day a week, she must be covered if she earns $50 or more in a quarter (approximately $3.85 per week). Domestic workers in farm homes come under the same provisions as farm workers.

A farm worker who earns $150 in cash wages during the year must be covered. However, farm workers who perform agricultural services for an employer on 20 or more days during a calendar year for cash at a rate based on some unit of time must be covered regardless of the rate.

Only cash is considered in wages paid to domestic or farm workers, not wages in kind.

Old Age and Survivors' Insurance Tax

The Old Age and Survivors' Insurance Tax is payable by every employer who employs **one or more persons** in his office or home.

There is an increase in the amount paid under OASI, brought about by the Social Security Amendments of 1958. Through December 31, 1958, the employer continues to deduct 2¼ per cent of the employee's wages and contribute a like amount himself. Through the current year, the amount is deducted and paid on the first $4,200 of annual salary.

Beginning January 1, 1959, the employer deducts 2½ per cent of the employee's wages and contributes another 2½ per cent himself.

Deductions and employer's payments beginning the first of the new year are made on the first $4,800 of annual salary.

The tax return and informational return, combined in one report, is to be filed quarterly. The tax must be paid and the return filed on or before April 30, for the months of January, February and March of that year, in the office of the District Director of Internal Revenue, and quarterly thereafter, payable during the month after the quarter ends.

The employer who hires household help only should file on Form 942, which is in the form of an envelope for convenient mailing. The employer who reports his office workers on Form 941 may add his domestic workers to this same form.

Farm workers must be reported on Form 943.

Unemployment Tax

Physicians or other employers who have **three** or more employees, including other physicians, nurses, receptionists, technicians, office workers, etc., are subject to the Ohio Unemployment Compensation Tax. Those who have **four or more** are liable also for the Federal Unemployment Insurance Tax.

Ohio Unemployment Compensation Tax

In general, employment of **three or more persons** in any one day including part-time workers renders the employer liable for this tax. A physician who is in doubt as to his liability, should request clarification from the Bureau of Unemployment Compensation, 427 Cleveland Ave., Columbus 16.

Reports are made during the month following each calendar quarter on forms supplied by the Bureau. The tax rate is established for each employer annually. A copy of the calculations made by the Bureau is mailed before the first of the year to each employer. This shows how the rate for the employer for that year was calculated. This rate starts at 2.7 per cent and may be reduced to as low as one-tenth of one per cent. Only the first $3,000 paid by any employer to any one individual within a calendar year is taxable.

Liable employers should furnish a form BUC-400 to each employee upon separation. These forms may be obtained from the local employment office. If the employee files a claim for benefits, the Bureau will request separation and wage information from the employer. It is imperative that this form requesting separation information be returned to the Bureau within seven days of its receipt.

Federal Unemployment Tax

The Federal Unemployment Insurance Tax applies to employers who have had **four or more persons** on their payrolls on 20 or more days in the calendar year, each of the 20 days being in different calendar weeks. It is payable to the District Director of Internal Revenue by January 31 for the previous year. The gross tax is three per cent on all individual wages up to $3,000 and is paid exclusively by the employer—the employee making no contribution. A credit not to exceed 90 per cent of this tax is allowed on all payrolls which were reported to the state unemployment compensation agency (see under Ohio Unemployment Compensation Tax) and the state tax paid by January 31. If an employer has paid his state unemployment tax in full, the Federal tax is reduced to three-tenths of one per cent.

OHIO WORKMEN'S COMPENSATION

The purpose of the Bureau of Workmen's Compensation is to maintain a Workmen's Compensation Insurance Fund from which to pay compensation to workmen for injury or occupational disease and compensation to dependents for death occasioned in the course of or arising out of employment.

Every employer in the state employing **three or more** employees regularly in the same business is required to furnish the Bureau of Workmen's Compensation with specified information about employees he has had during the previous year, and to contribute to the State Insurance and Occupational Disease Fund in an amount based on the payroll and at a premium rate based on the class of risk. (The employer under certain circumstances may elect under bond to comply with the provisions of the law by self-insuring the risk.)

Employers of **less than three** employees may voluntarily subscribe to and obtain insurance in the Fund.

Insurance accounts are adjusted and reports made for the first half and second half of the calendar year. Reports are due with premiums attached by September 1 for the first half of the year, and by March 1 for the second half of the year. Another requirement is an advance permanent deposit based on eight months estimated payroll for the periods January 1 - August 31 and July 1 - February 28, respectively.

The Bureau of Workmen's Compensation comprises 16 regional offices in addition to the central office in Columbus.

OHIO PERSONAL PROPERTY TAX

Returns under the Ohio Personal Property Tax Law must be made between February 15 and April 29 annually. One-half of the amount of

83% MAJOR (Grade I and II) IMPROVEMENT*

in Rheumatoid Arthritis

*Using combined drug therapy with **PLAQUENIL**® or Aralen® as maintenance therapy. With Plaquenil or Aralen alone 62% grade I and II improvement. (Scherbel, A.L.; Harrison, J.W., and Atdjian, Martin: Cleveland Clin. Quart. 25:95, April, 1958. Report on 805 patients with rheumatoid arthritis or related diseases.)

Reasons for Failure:

1. Treatment discontinued too soon (percentage of patients improved increases substantially after first six months).
2. Patients in relapse after prolonged steroid therapy are resistant to Plaquenil or Aralen treatment for several months.

Plaquenil sulfate is supplied in tablets of 200 mg., bottles of 100.

Dose: Initial — 400 to 600 mg.
(2 or 3 tablets) daily.
Maintenance — 200 to 400 mg.
(1 or 2 tablets) daily.

Write for Booklet.

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nd of hydroxychloroquine), trademarks reg. U.S. Pat. Off.

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the tax is paid when the return is filed, and the other half is due September 20.

It must be kept in mind that tangibles to be listed include personal property used in business, such as a physician's office furniture, fixtures, equipment, supplies (including medicines), etc. Such tangible property should be listed at its book value. A depreciation of 10 per cent annually from cost will be allowed until such equipment reaches a value of 30 per cent. It should stop at that figure for a year. Then such office equipment may be reduced 5 per cent each year until it reaches a minimum value of 20 per cent, which value should be kept as a utility value.

When a physician opens his practice (or a person starts in business) during the calendar year, he is required by law to list all his taxable property, except inventory, as of the date he engaged in practice. In listing inventory he should list the probable average value (at any one time) intended to be used between the time he engages in practice and the end of the year. The valuation of all taxable property including average inventory to be returned for taxation is determined by multiplying the value by the number of months the taxpayer has been in practice and dividing by 12.

Forms 937 and 902, obtained from the Ohio Department of Taxation, must be filed with the Personal Property Tax return to obtain a lesser value than 30 per cent.

Returns should be filed in duplicate. The so-called tangible tax statutes are intricate and complicated so each physician having taxable personal property for listing should obtain competent advice in case of doubt as to the meaning of any of the provisions of the law.

One of the complicated provisions of the tax law is that involving the listing of credits which are taxable at 3 mills on the dollar, and which involves the computation of accounts receivable.

Accounts receivable are to be listed in accordance with Section 5711.18 of the Revised Code part of which reads, "Claim for any deduction from net book value of accounts receivable or depreciated book value of personal property must be made in writing by the taxpayer at the time of making return," on supplementary tax form 902.

All taxable personal property and credits used in business shall be listed as of the close of business of the last day of December, annually.

As defined in Section 5701.07 R. C., credits "mean the excess of the sum of all current accounts receivable and prepaid items used in business when added together estimating every such account and item at its true value in money, over and above the sum of current accounts payable of the business, other than taxes and assessments."

The same section states that "current accounts include items receivable or payable on demand or within one year from the date of inception, however evidenced."

To arrive at a fair estimate of his current accounts receivable, the physician is advised to note after each account what he considers its value. If he believes the account can be collected in full, it should be listed at its full face value. Otherwise it should be listed at a percentage of its true value, or "no value" if that is the case. The total of these estimates is the amount to be entered as "current accounts receivable" and used in computing credits.

This procedure permits the physician to charge off bad debts. It also allows him to depreciate the actual value of accounts returned in the tax year, but which have decreased in actual value during that year.

Some physicians misunderstand the provision requiring the listing of accounts receivable for taxation. Some think that physicians are the only ones who have to do so and that the law is discriminatory. That is not true.

Every person who possesses intangible assets, *such as accounts receivable,* or any business or professional man who does buisness on credit basis and keeps books, must return his accounts receivable for taxation.

Such person must keep in mind that he can estimate depreciation on his accounts receivable and that he can use *accounts payable* as an offset against accounts receivable, paying the tax on the difference.

Obviously, the percentage discount used by a physician in depreciating the value of his accounts receivable will depend to a large extent on the doctor's collection experience and on the economic status of the majority of his patients. In other words the physician who has difficulty in collecting bills or whose practice serves a large number of persons in the low-income brackets or who are poor credit risks, should use a higher depreciation formula than the physician who does not have these factors to contend with.

OHIO SALES AND USE TAX

Section 5739.02 Revised Code levies an excise on each retail sale made in Ohio of tangible personal property.

The Ohio Use Tax Law, passed in 1936, supplements the Retail Sales Tax Law and imposes

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The great corticosteroid era
opened ten years ago
with the introduction of CORTONE® (cortisone).
Today, MERCK SHARP & DOHME proudly
presents the crowning
achievement of the first corticosteroid
decade—DECADRON (dexamethasone)
—a new and unique compound, which
brings a new order of magnitude
to corticosteroid therapy

Decadron*

DEXAMETHASONE

to treat more patients more effectively

MSD MERCK SHARP & DOHME

a new order of magnitude

In Anti-Inflammatory Potency

DECADRON "possesses greater anti-inflammatory potency per milligram than any steroid yet produced,"[1] and is "the most potent steroid thus far synthesized."[2] Milligram for milligram, it is, on the average, 5 times more potent than 6-methylprednisolone or triamcinolone; 7 times more potent than prednisone; 28 times more potent than hydrocortisone; and 35 times more potent than cortisone.

In Dosage Reduction

Thanks to this unprecedented potency, DECADRON is "highly effective in suppressing the manifestations of rheumatoid arthritis when administered in remarkably small daily milligram doses."[3] In a number of cases, doses as low as 0.5-0.8 mg. proved sufficient for daily maintenance. The average maintenance dosage in rheumatoid arthritis is about 1.5 mg. daily.

In Elimination and Reduction of Side Effects

Virtual absence of diabetogenic activity, edema, sodium or water retention, hypertension, or psychic reactions has been noted with DECADRON.[1,2,3,4] Other "classical" reactions were less frequent and less severe. DECADRON showed no increase in ulcerogenic potential, and digestive complaints were rare. Nor have there been any new or "peculiar" side effects, such as muscle wasting, leg cramps, weakness, depression, anorexia, weight loss, headache, dizziness, tachycardia or erythema. Thus DECADRON introduces a new order of magnitude in safety, unprecedented in corticosteroid therapy.

In Therapeutic Effectiveness

With DECADRON, investigators note "a decided intensification of the anti-inflammatory activity"[3] and antirheumatic potency.[4] Clinically, this was manifested by a higher degree of improvement in many patients, previously treated with prednisteroids,[3] and by achievement of satisfactory control in an impressive number of recalcitrant cases.[3,4]

In Therapeutic Range

More patients can be treated more effectively with DECADRON. Its higher anti-inflammatory potency frequently brings relief to cases resistant to other steroids. Virtual freedom from diabetogenic effect in therapeutic dosage permits treatment of many diabetics without an increase in insulin requirements. Absence of hypertension and of sodium and fluid retention allows effective therapy of many patients with cardiovascular disorders. Reduction in the incidence and severity of many side effects extends the benefits of therapy to numerous patients who could not tolerate other steroids. And a healthy sense of well-being, reported by nearly all patients on DECADRON, assures greater patient cooperation.

References:

1. Boland, E.W.: California Med. 88:417 (June) 1958.
2. Bunim, J.J., et al.: Arthr. & Rheum. 1:313 (Aug.) 1958.
3. Boland, E.W., and Headley, N.E.: Paper read before the Am. Rheum. Assoc., June 21, 1958, San Francisco, Cal.
4. Bunim, J.J., et al.: Paper read before the Am. Rheum. Assoc., June 21, 1958, San Francisco, Cal.

To treat more patients more effectively in all allergic and inflammatory disorders amenable to corticosteroid therapy

DOSAGE AND ADMINISTRATION

With proper adjustment of dosage, treatment may ordinarily be changed over to DECADRON from any other corticosteroid on the basis of the following milligram equivalence:

One 0.75 mg. tablet of DECADRON (dexamethasone) replaces:

↓ One 4 mg.	↓ One 5 mg.	↓ One 20 mg.	↓ One 25 mg.
tablet of methylprednisolone or triamcinolone	tablet of prednisolone or prednisone	tablet of hydrocortisone	tablet of cortisone

SUPPLIED:

As 0.75 mg. scored pentagon-shaped tablets; also as 0.5 mg. tablets to provide maximal individualized flexibility of dosage adjustment.

Detailed literature is available to physicians on request.

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Decadron*

DEXAMETHASONE

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a new order of magnitude in corticosteroid therapy!

The great corticosteroid era
opened ten years ago
with the introduction of CORTONE® (cortisone).
Today, MERCK SHARP & DOHME proudly
presents the crowning
achievement of the first corticosteroid
decade—DECADRON (dexamethasone)
—a new and unique compound, which
brings a new order of magnitude
to corticosteroid therapy

Decadron*

DEXAMETHASONE

to treat more patients more effectively

MSD MERCK SHARP & DOHME

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a tax on the same basis as the sales tax on purchases made outside the State. Its purpose is to protect Ohio merchants from discrimination. Many out-of-state firms have made arrangements with the Ohio Department of Taxation to add the amount of the tax to invoices covering purchases by Ohio consumers, collecting the tax and paying it directly to the Department.

However, if a physician purchases drugs or supplies from an out-of-state firm which has not made such an arrangement with the Tax Department, he is required to report such purchases to the Treasurer of State and pay the tax. Returns must be filed with the Treasurer by next April 15 for purchases, during the period January 1 to March 31, and quarterly thereafter. The report is filed on Ohio Use Tax Form 1014, "The Quarterly Consumers Return."

Section 5739.01, Revised Code, contains this provision: "Physicians, dentists, hospitals, and blood banks operated by non-profit institutions are consumers of all tangible personal property purchased by them in connection with the practice of medicine, dentistry, or rendering hospital or blood bank service. They shall not be required by any provision of Sections 5739.01 to 5739.31, inclusive, and 5741.01 to 5741.22, inclusive, of the Revised Code, to collect sales or use tax on property transferred by them to patients in connection with the rendition of professional services provided that if physicians, dentists, and hospitals are engaged in selling to consumers tangible personal property as received from others, such as eye glasses, mouth washes, dentifrices, or similar articles, the tax shall apply to such sales."

CITY PAYROLL TAX

About 30 cities in Ohio have enacted laws imposing income tax on wage earners and making the employer responsible for deducting the tax from wages paid employees. For example, Columbus has a law which requires the employer to deduct a percentage of the employee's wages and make returns to the city auditor quarterly. (Refer to March issue of *The Journal,* page 346). A physician who moves into a new location should inquire as to what tax laws may be in force locally.

Homicide Rate Down

In contrast to the marked increase in major crimes, the incidence of homicide in the United States has decreased in the period since World War II, it is reported by statisticians of the Metropolitan Life Insurance Company. The age-adjusted homicide rate fell about one fifth between 1946-47 and 1955-56, from 6.1 to 4.8 per 100,000 of population.

Congress on Industrial Health In Cincinnati, Feb. 16-18

Ohio physicians will have a fine opportunity to get refresher work in industrial medicine at Cincinnati on next February 16, 17 and 18 when the Annual Congress on Industrial Health of the American Medical Association will be held at the Netherland Hilton Hotel.

The theme of the meeting will be "Occupational Medicine — Education, Research and Practice." Dr. Robert A. Kehoe, Cincinnati, is general chairman. Some of the topics which will be discussed are: undergraduate and postgraduate education in the field of industrial health; training fellowships and in-plant training; medical research including toxicology; odor detection, ozone toxicology, noise, radiation, etc. A detailed program will be published in a later issue of *The Journal.*

New National Civil Defense Plan Outlined

Office of Civil and Defense Mobilization, in a 32-page report, has outlined the national plan for civil defense and defense mobilization under three major contingencies: international tension, limited war and general war, including massive nuclear attack. The plan has been promulgated in accordance with Reorganization Plan No. 1 of 1958, which merged Federal Civil Defense Administration with the Office of Defense Mobilization into the new OCDM.

"All citizens and governments at all levels, by virtue of their inherent obligation to support the common defense, are jointly responsible for the civil defense and defense mobilization of the nation," the plan states. The federal government is responsible for direction and coordination of the total national effort; the states are responsible for direction and coordination of activities and its political subdivisions, and local governments for programs of their subdivision.

For disaster services the agency said states and subdivision, with help from Uncle Sam, will stockpile necessary medical supplies and equipment and recruit and train personnel in disaster services.

OCDM Director Leo A. Hoegh said the principles outlined in the national plan would be supported later by a series of 40 annexes, including one on a national medical and health plan. It is being drawn up by the Department of Health, Education, and Welfare which has been given broad responsibilities in the health field in time of national emergency.

Six Poison Centers Serve Ohio . . .

OSMA Committee on Poison Control Recommends that Every Physician Clip This Box and Post It Near His Telephone for Ready Reference

Poison Information Centers in Ohio Currently in Operation

Location	Facility	Telephone
Akron	Children's Hospital W. Bowery and W. Bechtel	BL 3-5531, Ext. 246
Cincinnati	The Academy of Medicine of Cincinnati 152 E. Fourth St.	PA 1-2345
Columbus	Children's Hospital 561 S. 17th St.	CL 8-9783
Cleveland	Cleveland Academy of Medicine 2121 Adelbert Road	CE 1-4455
Springfield	City Hospital E. High St. and Burnett Rd.	FA 3-5531, Ext. 226
Toledo	Toledo Health Department 635 N. Erie St.	CH 4-1961—(Day) GR 9-2244—(Night)

These centers have agreed to cooperate in a program to extend their services to any physician requesting information from them. When a center is called the physician should have four basic facts in mind:

1. The full name or brand of the product ingested or inhaled or, in the case of plant poisoning, the common and generic name if available.
2. An accurate estimation of the amount of the particular agent ingested or if this cannot be ascertained the maximum amount that could possibly have been ingested.
3. The time of ingestion.
4. The age and weight of the patient.

Pressure for U. S. Medical Aid to Aged Building Up, Official Says

HEW Assistant Secretary Elliot Richardson sees increased pressure on the government for action on health care of the aged. Addressing the American Public Health Association, the No. 3 man in HEW warned: "Unless private, voluntary or local solutions to these and similar problems are found, the pressure for action at higher levels of government will continue to mount." Too few communities, he claimed, have adequate facilities for long-term care of the chronically ill and dependent elderly persons, and very few places pay full costs for the hospital care of the indigent, many of whom are aged.

"For these and other reasons, the cost of health care for the aged has become a political problem of great moment," Mr. Richardson declared. "It will not go away. The real issues center around the degree of public action thereby demanded . . . Some would say that far more federal action is needed; others insist that Uncle Sam is already in too deep."

Mr. Richardson's conclusion: ". . . despite recent progress by private and voluntary institutions in helping the aged to meet the costs of health care, the remaining gaps are serious and difficult to close. The activities of local jurisdiction, moreover, in working out solutions to the health problems of the aged are spotty, sporadic, and for the most part, inadequate."

Two appointments in the American College of Cardiology were announced recently by Dr. J. P. Harvey, governor for Ohio: Dr. Elmer A. Schlueter, deputy governor for the Cincinnati District, and Dr. R. W. Kissane, deputy governor for the Columbus District.

Institute on Steroid Therapy Offered in Columbus

An Institute on Steroid Therapy, sponsored by the Columbus Medical Center Research Foundation, and presented under the auspices of the Department of Medicine of Ohio State University School of Medicine, has been announced for January 8.

Place is the Ohio Union on the Ohio State University Campus and the time, 9:00 a. m. to 5:30 p. m. All Ohio physicians are invited. There will be no fee.

The faculty includes the following guest speakers plus members of the OSU College of Medicine faculty:

Darrell C. Crain, Jr., M. D., assistant professor of clinical medicine, Georgetown University, Washington, D. C.

Leon Goldman, M. D., professor of dermatology, University of Cincinnati.

Dan M. Gordon, M. D., assistant professor of ophthalmology, Cornell University, New York City.

Philip S. Hench, M. D., consultant, The Mayo Clinic, Rochester, Minn.

Bram Rose, M. D., associate professor of medicine, McGill University, Montreal, Canada.

Lewis H. Sarett, Ph. D., chief chemist, Merck Sharp & Dohme Research Laboratories, Rahway, New Jersey.

Details may be obtained by writing: Norman O. Rothermich, M. D., The Columbus Medical Center, 1211 Dublin Road, Columbus 8, Ohio.

The course is eligible for American Academy of General Practice credit.

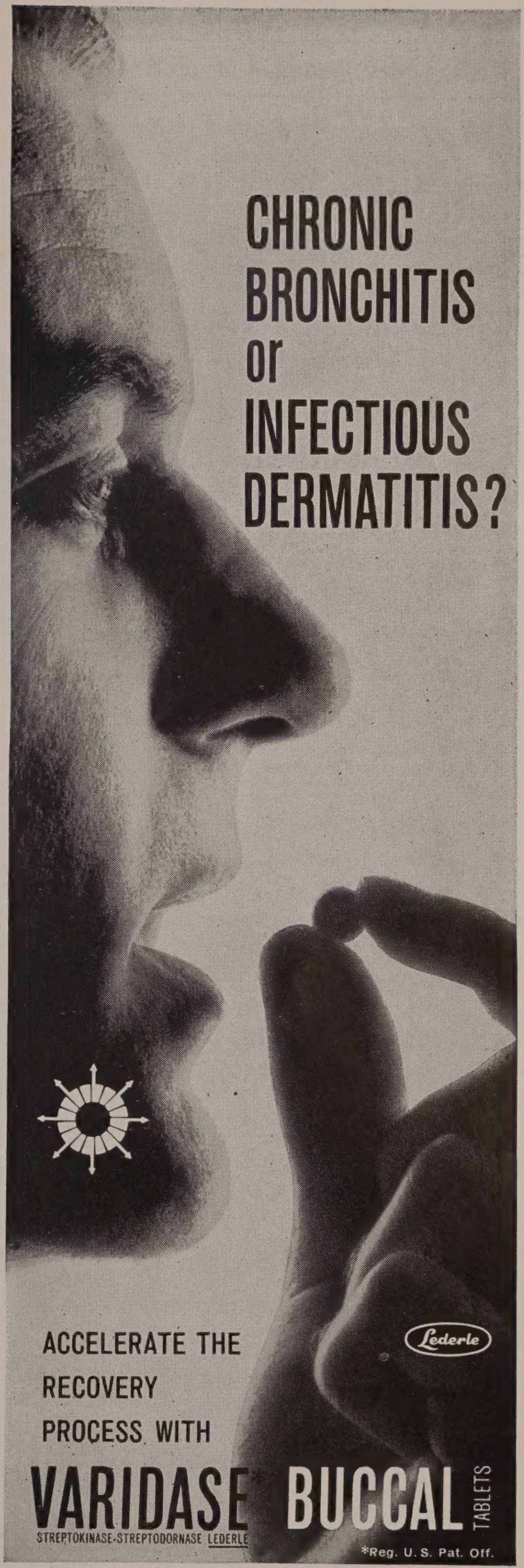
Cincinnatians Participate in Radiological Program

Three Cincinnatians had roles in the Radiological Society of North America meeting recently in Chicago.

Dr. Benjamin Felson, director of the department of radiology, University of Cincinnati College of Medicine, presented a refresher course on "Fundamentals of Chest Roentgenology." Dr. Eugene L. Saenger, UC associate clinical professor of radiology, gave a refresher course on "The Therapeutic Application of Radioisotopes."

Dr. Frederic N. Silverman, UC associate professor of radiology and pediatrics, read a paper on "Congenital Insensitivity to Pain."

Women see physicians more often than men do, especially at the ages of 15 through 44. During childhood, however, boys receive more medical care than girls.—Health Information Foundation.


CHRONIC BRONCHITIS or INFECTIOUS DERMATITIS?
ACCELERATE THE RECOVERY PROCESS WITH
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LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

New Members of OSMA

The following are the names of the new members of the Ohio State Medical Association since October 1, 1958. The list shows the county in which they are affiliated, city in which they are practicing or temporary address in cases where physicians are taking postgraduate work.

Butler County

John W. Barnes, Middletown
Brady F. Randolph, Jr., Hamilton
Miles M. Vance, Hamilton

Clark County

Edwin A. Roberts, Springfield
David D. Smith, Springfield

Cuyahoga County

Robert B. Ainslee, Cleveland
Robert C. Griggs, Cleveland
George N. Lipsky, Cleveland
Arthur D. Weatherhead, Cleveland

Franklin County

Raymond E. Barker, Columbus
James F. Beattie, Columbus
Peter P. Bosomworth, Waukegan, Ill.
Charles H. Hamilton, Fort Deposit, Maryland
Franklin L. Lyon, Columbus
James F. Mason, Columbus
Richard D. Ruffin, Columbus

Hamilton County

Irving Marcus, Cincinnati
Karel Polesny, Cincinnati
Richard G. Schaefer, Cincinnati

Hancock County

Alfred P. Bukeavich, Findlay
Manuel Sarmina, Findlay

Lake County

Joseph J. Maher, Painesville
Duane N. Tweeddale, Painesville

Lawrence County

Warren N. Morford, Chesapeake

Lucas County

Anthony P. Russo, Toledo

Montgomery County

Thomas C. H. Hwang, Dayton

Wood County

LeRoy J. Eulberg, Pemberville
Jarl B. Nordman, Luckey

Three Institutions Receive H. B. 384 Certification

Three more Ohio institutions were certified by the Ohio Public Health Council October 25 as eligible to obtain from pounds unlicensed, abandoned dogs under provisions of the 1957 Animal Research Act.

They include Christ Hospital Institute of Medical Research, operated by The Elizabeth Gamble Deaconess Home Association, Cincinnati; Maumee Valley Hospital Research Laboratory, Toledo, and Doctors Hospital, Columbus. This brings to 32 the number of institutions so certified since the Act became effective in September of 1957.

Doctors' Radio Service Sought

The AMA has filed a petition with the Federal Communications Commission in Washington requesting that it allocate radio frequencies for the exclusive use of the nation's physicians.

The petition asked the FCC to change its rules so that the medical profession could set up a private two-way mobile radio service of its own which would be known as Physicians' Radio Service.

For Real Pain ...give real relief:

A.P.C. WITH Demerol® tablets

Each tablet contains:

Aspirin .... 200 mg. (3 grains)
Phenacetin .... 150 mg. (2½ grains)
Caffeine .... 30 mg. (½ grain)
Demerol hydrochloride.... 30 mg. (½ grain)

Average Dose:

1 or 2 tablets.

Narcotic blank required.

Potentiated Pain Relief

WINTHROP LABORATORIES
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Demerol (brand of meperidine),
trademark reg. U.S. Pat. Off.

whenever
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starts
to

CHEW

he's
ready
for

Delectavites®

New vitamin-mineral supplement
in delicious chocolate-like nuggets

There's nothing easier to give
or take–
than Delectavites.
A real treat . . .
the children's favorite . . .
tops with adults, too.

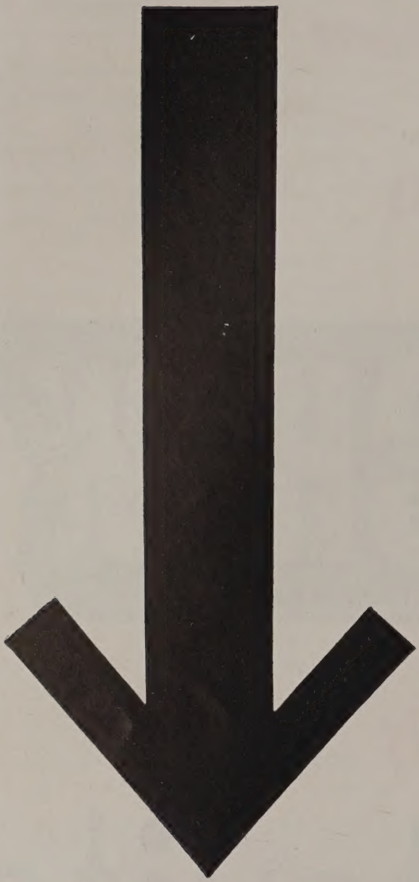
Whites
WHITE LABORATORIES, INC.,
KENILWORTH, N. J.

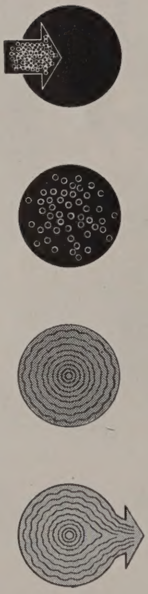
Each nugget contains:

Vitamin A	5,000 Units*
Vitamin D	1,000 Units*
Vitamin C	75 mg.
Vitamin E	2 Units†
Vitamin B-1	2.5 mg.
Vitamin B-2	2.5 mg.
Vitamin B-6	1 mg.
Vitamin B-12 Activity	3 mcg.
Panthenol	5 mg.
Nicotinamide	20 mg.
Folic Acid	0.1 mg.
Biotin	30 mcg.
Rutin	12 mg.
Calcium Carbonate	125 mg.
Boron	0.1 mg.
Cobalt	0.1 mg.
Fluorine	0.1 mg.
Iodine	0.2 mg.
Magnesium	3.0 mg.
Manganese	1.0 mg.
Molybdenum	1.0 mg.
Potassium	2.5 mg.

*U.S.P. UNITS †INT. UNITS

Dose: One Nugget per day
Supplied: Boxes of 30—one month's supply
Boxes of 90—three months' supply or family package.





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AVAILABLE in three pleasant-tasting formulas:

for the average patient
KONDREMUL (Plain)
containing 55% mineral oil. Bottles of 1 pint.

for more hypotonic cases
KONDREMUL WITH CASCARA
0.66 Gm. non-bitter Ext. Cascara per tablespoonful.
Bottles of 14 fl.oz.

for more resistant constipation
KONDREMUL WITH PHENOLPHTALEIN
0.13 Gm. (2.2 gr.) phenolphthalein per tablespoonful.
Bottles of 1 pint.

patch **THE E. L. PATCH COMPANY** Stoneham, Massachusetts

70 YEARS OF SERVICE TO THE MEDICAL PROFESSION

---

*Unique encapsulation of millions of minute oil globules by Irish moss assures complete penetrant diffusion in stools.

Number of Veterans After Reaching Peak Has Begun To Decline

For the first time since the days of World War II the estimated number of veterans in civilian life is showing a consistent downward trend, Sumner G. Whittier, administrator of Veterans Affairs, reported.

There were an estimated 22,723,000 veterans in civil life on September 30, 1958.

Increasing steadily as the servicemen of, first, World War II and then of the Korean Conflict returned from the ranks of the military to civilian pursuits, the number of veterans in the nation reached an all-time high of 22,735,000 in March, 1958.

Up until that time, the number of servicemen becoming veterans during the average month exceeded the number of veterans of all wars who died each month, or who returned to active duty.

The drop to 22,723,000 on September 30 marked the sixth consecutive month the total veteran population had shown a decrease.

The total drop during the 6-month period was 12,000 and was strong indication that, after 19 years of increase, the number of war veterans in the nation was on a downward trend.

Barring another war, the decline will continue without interruption, the Administrator pointed out, unless there should be an unforeseen increase in the discharge rate of Korean Conflict veterans from the armed forces.

Ohio State University Rates High On Aviation Medicine Program

Ohio State University's training of physicians for civilian aviation has placed the United States ahead of other nations in the field, Dr. William F. Ashe, chairman of the Preventive Medicine Department, said in an interview with the public press.

The first civilian residency for aviation medicine, the three-year program for physicians was placed in operation in 1956 and still is the only one recognized by the American Board of Preventive Medicine.

Dr. Ashe, asserting he is "confident" the U. S. has outdistanced Belgium and Switzerland, only early leading contenders, predicted a growing demand for qualified doctors in commercial aviation.

Dr. Ashe started groundwork for the program shortly after his arrival at Ohio State in 1954. The residency program is the product of an aviation physiology laboratory, founded by Dr. Fred Hitchcock in 1941, and an aviation medicine series begun in 1951 under direction of Dr. Richard L. Meiling, associate dean of the College of Medicine.

NEW 3-WAY "PICKUP"
FOR APPREHENSIVE AND/OR
HYPERTENSIVE PATIENTS

NEO-SLOWTEN®
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A TRANQUILIZING COMBINATION

- relieves anxiety, irritation, fatigue
- reduces mild elevated blood pressure
- refreshes neural tone

EACH WHITE, SCORED TABLET CONTAINS:

Phenobarbital . . . . . . 16.2 mg. (¼ gr.)
Warning: May be habit-forming
Reserpine . . . . 0.1 mg.
Thiamine hydrochloride . . . . 5.0 mg.

SUPPLIED: Bottles of 100 scored tablets.

patch **THE E. L. PATCH COMPANY**
Stoneham, Massachusetts

70 YEARS OF SERVICE TO THE MEDICAL PROFESSION

Exactly how does new Halodrin* restore the "premenopausal prime" in postmenopausal women?

Webster defines "prime" as the period of greatest health, strength, and beauty. In a woman, these are the childbearing years between puberty and menopause—the years when her hormone production is highest.

The inevitable reduction in this hormone production as she enters the menopause often results in physical discomfort in the form of hot flushes, nervousness, insomnia, or a multiplicity of other symptoms with which you are familiar. Superimposed on this physical picture is the psychic trauma brought on by this unavoidable evidence of aging. The thing that brings her to a physician is simply that she "feels bad."

You can't make her 35 again—but the odds are good that you can make her feel like it! The secret is a combination of reassurance and hormones. The exact form and amount of the former defy objective analysis, but the latter can now be provided with scientific precision. Reduced to essentials, here is the explanation of exactly how hormones—in the form of Upjohn's new Halodrin—restore the "premenopausal prime."

The normal premenopausal woman excretes estrogens in the urine in the form of estradiol, estrone, and estriol, in an approximate 28-day average ratio of 39:15:46. Starting with this urinary excretion of estrogens, it is possible to calculate backwards and estimate the amount of estradiol that must have been secreted endogenously in order to produce these urinary levels. This is possible because the proportion of estrogens which appears in the urine following parenteral administration has been established in castrated women.

On this basis, the average endogenous output of estrogens is about 160 micrograms per day during a menstrual cycle, and 80 micrograms per day in postmenopausal women (see chart opposite). Therefore, the restoration of the "premenopausal prime" in the postmenopausal woman requires the replacement of approximately the equivalent of the 80 micrograms of estradiol per day that she no longer secretes endogenously.

Oral ethinyl estradiol is about 2 to 2½ times as potent as parenteral estradiol. Therefore, **the replacement of 80 micrograms of endogenous estradiol production per day is accomplished by the oral administration of 32 to 40 micrograms of ethinyl estradiol per day.**

Each Halodrin tablet contains 20 micrograms of ethinyl estradiol, which means that the recommended dosage of 2 tablets per day provides 40 micrograms of ethinyl estradiol. This offsets the loss of 80 micrograms of endogenous estradiol production in the menopausal woman; i.e., restores the "premenopausal prime."

Each Halodrin tablet also contains 1 mg. of Upjohn-developed Halotestin* (fluoxymesterone)—the most potent oral androgen known. The primary purpose is to "buffer" the ethinyl estradiol just enough to prevent breakthrough bleeding, which is obviously undesirable in the menopause. It also exerts other beneficial hormonal effects, one of which, in common with ethinyl estradiol, is a powerful anabolic action so desirable in patients of advanced years.

Upjohn

*TRADEMARK, REG. U. S. PAT. OFF.

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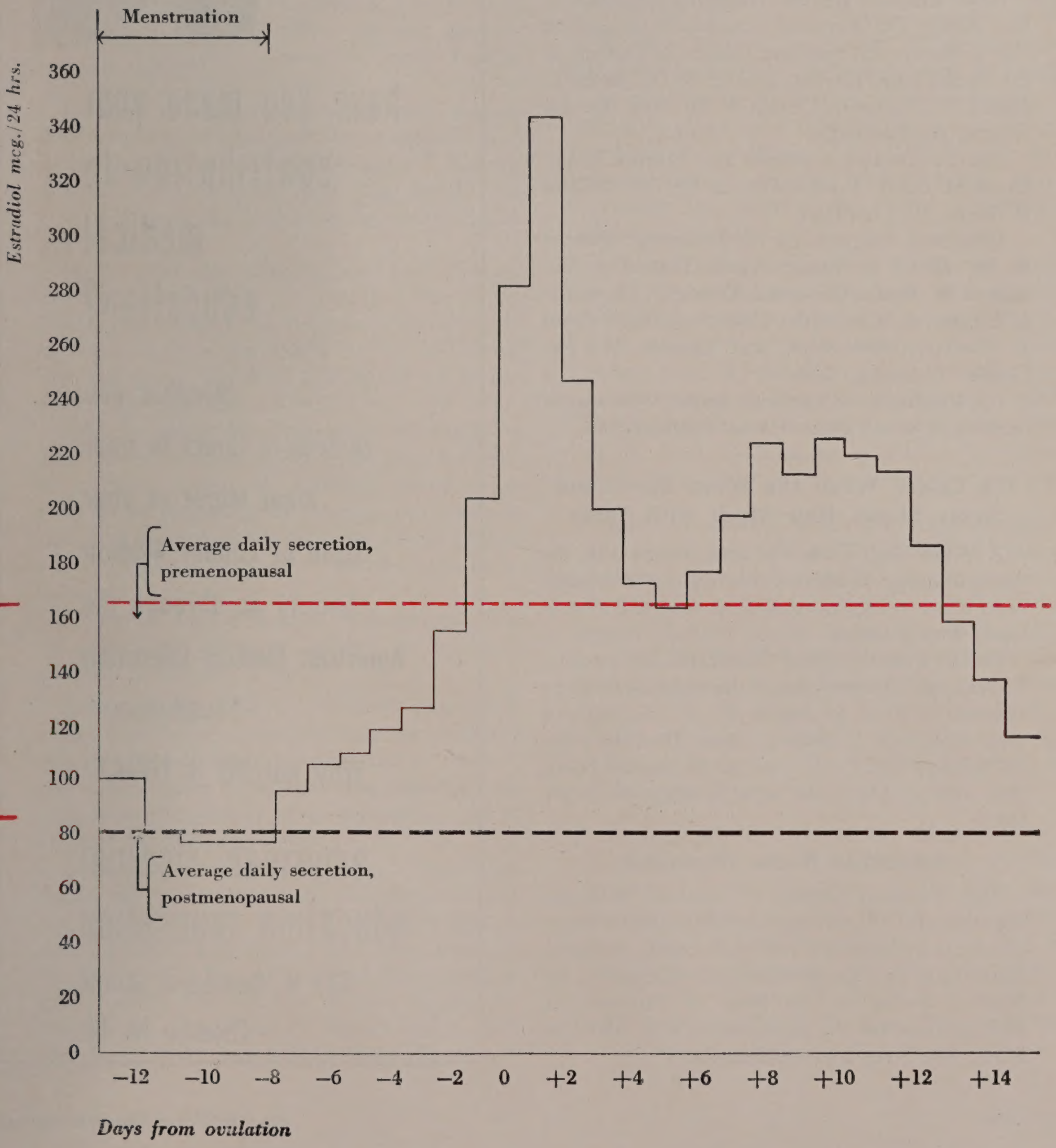
Endogenous estrogen secretion (mcg./24 hours)
(calculated from average 24-hour urinary excretion
of estradiol, estrone, and estriol)



Ohio Academy of General Practice Elects Officers for Year

The Ohio Academy of General Practice at its recent annual meeting in Toledo named Dr. Lewis W. Cellio, Cincinnati, as president-elect. He will assume the presidency at the 1959 annual meeting in Columbus the week of September 14. Dr. Cellio has been the speaker of the house.

Dr. Charles R. Marlowe, Toledo, was installed as president to succeed Dr. Earl C. Van Horn, Cincinnati.

Other officers and key persons are: Dr. Howard R. Mitchell, Sr., Columbus, re-elected treasurer; Dr. Roger A. Peatee, Bowling Green, speaker of the house; and Dr. Raymond M. Kahn, Dayton, vice-speaker.

New directors are the following: District 1, Dr. Albert D. Weyman, Cincinnati, to succeed Dr. J. Robert Hudson who resigned; District 2, Dr. Paul Troup, Dayton; District 6, Dr. James L. Fisher, Youngstown; District 8, Dr. John Quincy Adams, Jr., Zanesville.

District directors re-elected are: District 4, Dr. Frank M. Good, Toledo; District 10, Dr. William P. Smith, Jr., Columbus.

Hold-over delegates are the following: District 3, Dr. David L. Steiner, Lima; District 5, Dr. Eugene W. Peters, Cleveland; District 7, Dr. Lewis L. Liggett, St. Clairsville; District 9, Dr. William J. Hartlage, Sciotoville; and District 11; Dr. Charles J. Cooley, Oberlin.

Approximately 883 persons attended the annual meeting of which about 538 were physicians.

It's Colder When the Wind Blows and Army Shows How Much with Table

A Wind Chill Table has been designed by the Army to gauge in advance severity of the weather in an effort to further reduce the incidence of cold injury among troops.

Results from the Wind Chill Table are startling. For example, it shows that if the temperature to be expected is about 35 degrees F. and the expected wind velocity is 20 miles per hour, then the effect on exposed flesh is the same as 38 degrees below zero with no wind—the same as being in a deep freeze.

Internists Name Executive

The American Society of Internal Medicine, organized in 1957, will have its first full-time executive secretary January 1. He is Robert L. Richards, Harrisburg, Pa., assistant executive director of the Medical Society of the State of Pennsylvania. Headquarters for the organization is at 350 Post Street, San Francisco 8, California.

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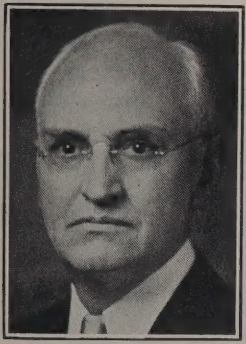
Whether you contribute direct to your Alma Mater or your State or County Medical Society or, through the American Medical Education Foundation —

Why not DO IT TODAY?

american medical education foundation
535 N. Dearborn Street
Chicago 10, Ill.

In Memoriam . . .

John Alexander Caldwell, M. D., prominent surgeon in Cincinnati for many years and a Past-President of the Ohio State Medical Association, died on November 9 at the age of 81.


Dr. Caldwell

A native of Cincinnati where his father was mayor and Congressman, Dr. Caldwell practiced there from the completion of his medical training to his retirement several years ago. He received his medical degree from the Miami Medical College of Cincinnati in 1902 and did graduate work at Cornell University.

Professor of clinical surgery for many years at the University of Cincinnati, Dr. Caldwell was a diplomate of the American Board of Surgery, member of the American Association for the Surgery of Trauma and Fellow of the American College of Surgeons.

Dr. Caldwell was active for many years in medical organization work. A Past-President of the Academy of Medicine of Cincinnati, he was elected to The Council of the OSMA in 1928 and served as Councilor of the First District before he was named President-Elect in 1933.

After serving as President of the Association in 1935-36 and completing his service on The Council as Past-President, Dr. Caldwell served several years on the Committee on Workmen's Compensation and many years as chairman of the Judicial and Professional Relations Committee prior to his retirement.

He moved from Cincinnati to Burlington, Ky., 13 years ago. Survivors include his widow, a daughter, a son and a sister.

Robert C. Paul, M. D., Wooster, outstanding example of the physician who met the challenges of a rapidly advancing technical age of medicine and science while at the same time upholding the time-honored traditions of the profession, died on October 28 at the age of 97.

Dr. Paul was born in a log cabin at Port Washington before the Civil War. He engaged in several early occupations, began teaching school at the age of 17, read medicine for three years under Dr. Eli Pocock of Shreve and received his medical degree from the University of Wooster Medical Department in 1892. When Dr. Pocock died in 1893, Dr. Paul moved his practice from Fostoria to Shreve and began his long service to the people of Wayne County. He moved to the county seat, of Wooster, in 1914. Dr. Paul practiced a total of 66 years and continued to see patients until less than a year ago.

Dr. Paul

In Wayne County he devoted much time to medical organization work; was a past-president and for many years secretary of the Wayne County Medical Society. He was a member of the Ohio State Medical Association and the American Medical Association. He was honored on numerous occasions for his service to the community by his colleagues and by community leaders, and was a recipient of the OSMA 50-Year Award. Dr. Paul shortly after moving to Wooster helped to incorporate and improve the former Kinney and Knestrick Hospital.

He was active in numerous community affairs; was a 70-year member of the Masonic Lodge, had a 26-year perfect attendance record with the Kiwanis Club, served on the selective service boards during both World Wars, and for many years directed the choir in the local Christian Church. Before the turn of the century he was an officer in the local National Guard Unit. A widower since 1938, Dr. Paul is survived by two nephews.

Elisha Blackburn, M. D., Worthington; University of Wooster, Medical Department, Cleveland, 1903; aged 85; died October 13; former member of the Ohio State Medical Association. Dr. Blackburn began his professional career as a medical missionary for the Friends Church in British East Africa where he served from 1903 to 1916. From 1922 to his retirement in 1950 he practiced in Kalida, Putnam County. Surviving are two daughters and a son, Dr. John H. Blackburn, of Worthington.

George W. Burner, M. D., Johnstown; Columbus Medical College, 1892; aged 95; died October 15; former member of the Ohio State Medical Association. Dr. Burner practiced for many years in the Johnstown area. He was recently making his home with a granddaughter in Marysville. During World War I, he served with the Army Medical Corps in France and later

(Continued on Page 1654)

THE RATIONALE FOR THE USE OF VITAMINS IN FORESTALLING INFECTIONS

Many clinicians believe that good nutrition plays a significant role in preventing bacterial infections, and that immunity depends on adequate vitamin levels. Tisdall[1] states that "a low intake of a number of vitamins, a low intake of minerals, and a change in the quality of protein can all lower resistance to infection."

Other studies show the important role of the B vitamins in antibody formation. Thus, *Nutrition Reviews*[2] reports: "Present evidence indicates that certain B vitamins, notably pyridoxine, pantothenic acid and folacin, play a significant role in antibody synthesis." According to Pollack and Halpern,[3] "Under-nutrition leads to increased susceptibility to infection and decreased resistance to established disease." And "vitamin deficiency states also may adversely influence circulating antibodies."

Halpern[4] reports that "good nutrition is important for optimal resistance to infection, for a superior tissue capability to cope with disease and injury, and for maximum antibody production . . . nutrition participates in the prophylaxis against most acute infections . . ."

And while MacBryde[5] feels that evidence is lacking to support the view that a higher than normal intake of vitamins will improve resistance to infection, he also states: "Restoration of nutrition to normal exerts a favorable influence on practically all disease conditions . . . Often the outcome will depend more upon the correction of the malnutrition than upon any therapy directed toward the malady."

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SQUIBB VITAMINS FOR THERAPY

now expanded to include additional essential vitamins—

and at no extra cost to your patients

Each Theragran Capsule supplies:

Vitamin A	25,000 U.S.P. units
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Thiamine Mononitrate	10 mg.
Riboflavin	10 mg.
Niacinamide	100 mg.
Ascorbic Acid	200 mg.
Pyridoxine Hydrochloride	5 mg.
Calcium Pantothenate	20 mg.
Vitamin B_{12} Activity Concentrate	5 mcg.

Dosage: 1 or more capsules daily as indicated.

Supply: Family Packs of 180. Bottles of 30, 60, 100 and 1,000.

Also Available: THERAGRAN Liquid, bottles of 4 ounces; THERAGRAN Junior bottles of 30 and 100 capsules; and THERAGRAN-M (Squibb Vitamin-Minerals for Therapy), bottles of 30, 60, 100 and 1,000 capsule-shaped tablets.

References: 1. Tisdall, F. F.: Clinical Nutrition, ed. by Joliffe, N.; Tisdall, F. F., and Cannon, P. R.: Paul B. Hoeber, Inc., New York, 1950, p. 748. 2. Nutrition Reviews, *15*:47, (Feb.) 1957. 3. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 18. 4. Halpern, S. L.: Ann. N. Y. Acad. Science *63*:147, (Oct. 28) 1955. 5. MacBryde, C. N.: Signs and Symptoms, J. B. Lippincott Co., Phila., 3rd Ed. 1957, p. 818.

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became an active member of the American Legion. He also was a member of the Methodist Church.

Laurence B. Chenoweth, M. D., Cincinnati; Johns Hopkins University School of Medicine, 1919; aged 67; died October 17; member of the Ohio State Medical Association and the American Medical Association. Dr. Chenoweth retired in 1956 as director of the University of Cincinnati Student Health Service after serving with the university for 36 years. Author of several books in his field, he was a past-president of the American College Health Association; also a member of the Ohio Student Health Association, and a number of other organizations. He is survived by his widow, a son and two daughters.

Oren I. Dusthimer, M. D., Zanesville; Ohio Medical University, Columbus, 1906; aged 82; died October 13; member of the Ohio State Medical Association and the American Medical Association. A practicing physician in Zanesville for about 46 years, Dr. Dusthimer devoted a total of 52 years years to his profession, and was a recipient of the OSMA 50-Year Award. Associations included memberships in the Exchange Club and the Presbyterian Church. Surviving are a daughter and a son.

Narvel Howard Foster, M. D., Gallipolis; University of Cincinnati College of Medicine, 1939; aged 50; died October 22; recent member of the Ohio State Medical Association and the American Medical Association. Dr. Foster served all of his professional career in Gallipolis where he was active in numerous civic affairs. He was a past-president of the local Kiwanis Club and former lieutenant governor of the Kiwanis district. Other local organizations in which he was active included the city and county boards of health, the Presbyterian Church, the County Tuberculosis Association and the County Junior Fair. Surviving are his widow, two sons, two sisters and four brothers.

Reuel M. Fullerton, M. D., Lakewood and Bay Village; Western Reserve University School of Medicine, 1924; aged 62; died October 25; member of the Ohio State Medical Association and the American Medical Association. A practitioner for many years in the area, Dr. Fullerton was for 17 years physician for the Lakewood High School. A veteran of World War I, he was active in a number of organizations, among them several Masonic bodies and the Congregational Church. He is survived by his widow, a daughter and his mother.

John P. Harbert, M. D., Bellefontaine; Eclectic Medical College, Cincinnati, 1898; aged 84; died October 20; member of the Ohio State Medical Association, the American Medical Association and the American Academy of Ophthalmology and Oto-Laryngology. A practicing physician in the Bellefontaine area for many years, Dr. Harbert operated a local hospital under his name from 1920 until 1943. He was a former county coroner and took active part in a number of organizations, among them the Red Cross, the Presbyterian Church and several Masonic bodies. Surviving are his widow and two sons.

Sims S. Hindman, M. D., Wyandotte, Mich.; Vanderbilt University School of Medicine, 1900; aged 79; died October 6; former member of the Ohio State Medical Association; member of the American Clinical Society of Pathologists. Dr. Hindman practiced 35 years in Toledo and for 20 years was pathologist for the Riverside Hospital. He retired five years ago and moved first to North Carolina, moving recently to Wyandotte where he made his home with a daughter. Two daughters survive.

Milton E. Jones, M. D., Ocean City, Md.; University of Maryland School of Medicine and College of Physicians and Surgeons, 1915; aged 70; died October 21; member of the Ohio State Medical Association and the American Medical Association. Dr. Jones practiced for many years in Columbus where his specialty was urology. He retired several years ago and moved to Maryland where his widow survives.

Edward J. Kennedy, M. D., Cincinnati; University of Cincinnati College of Medicine, 1913; aged 68; died October 1; former member of the Ohio State Medical Association. A practicing physician in Cincinnati for many years, Dr. Kennedy was serving on the staff of the Veterans Administration Hospital there. He also was former physician for the police and fire departments. He was a veteran of World War I during which he served in Europe. Survivors include his widow, a daughter and three sons.

Edith C. Kline, M. D., Columbus; Woman's Medical College of Pennsylvania, 1905; aged 82; died November 6; former member of the Ohio State Medical Association and the American Medical Association. Dr. Kline practiced medicine in Columbus for 42 years before her retirement in 1947. She was a member of the Methodist Church, the Altrusa Club and the American Association of University Women. Surviving are a sister and a brother, Dr. O. E. Kline, of Westerville.

Pearl D. Longbrake, M. D., Marysville; Ohio Medical University, Columbus, 1897; aged 83; died October 24; member of the Ohio State Medi-

Annual Clinical Conference

CHICAGO MEDICAL SOCIETY

MARCH 2, 3, 4, and 5, 1959

Palmer House, Chicago

Daily Half-Hour Lectures by Outstanding Teachers and Speakers on subjects of interest to both general practitioner and specialist

Panels on Timely Topics

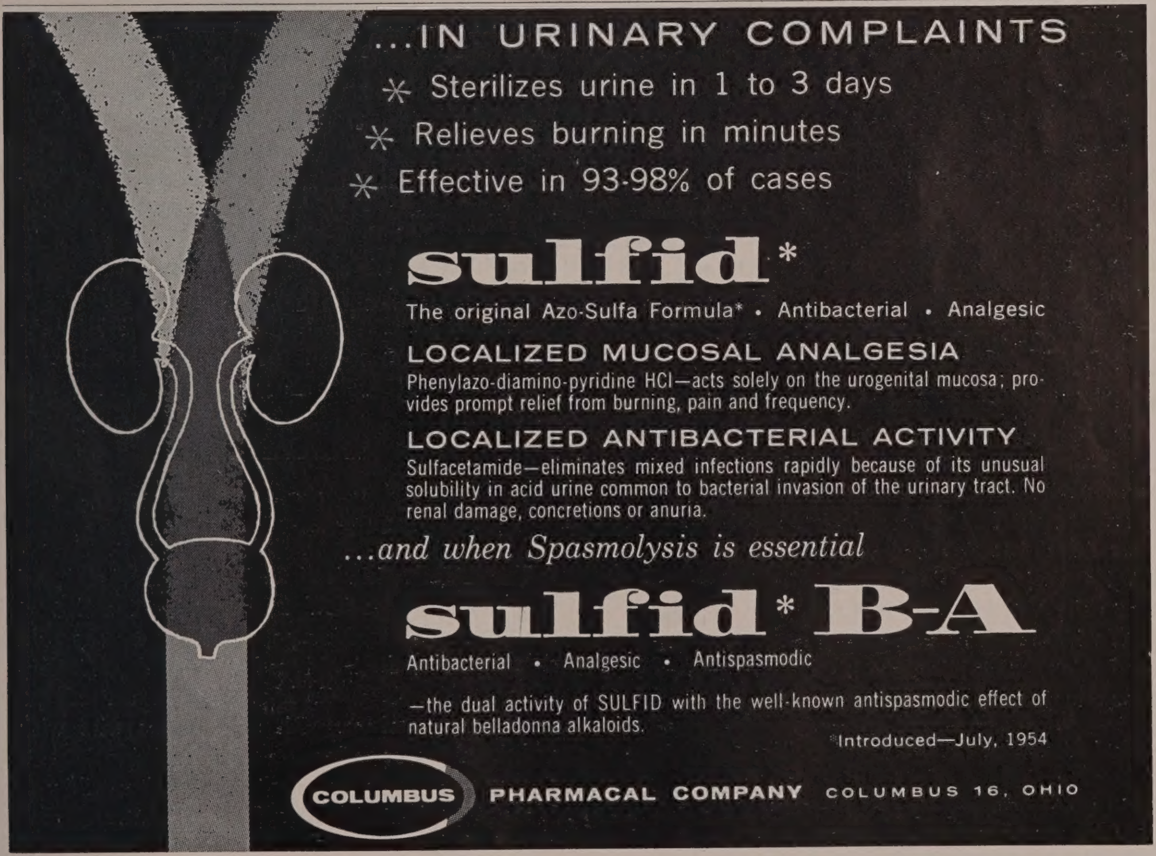
Teaching Demonstrations

Medical Color Telecasts

Instructional Courses

Scientific Exhibits worthy of real study and helpful and time-saving Technical Exhibits

The Chicago Medical Society Annual Clinical Conference should be a MUST on the calendar of every physician. Plan now to attend and make your reservation at the Palmer House.



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The original Azo-Sulfa Formula* • Antibacterial • Analgesic

LOCALIZED MUCOSAL ANALGESIA

Phenylazo-diamino-pyridine HCl—acts solely on the urogenital mucosa; provides prompt relief from burning, pain and frequency.

LOCALIZED ANTIBACTERIAL ACTIVITY

Sulfacetamide—eliminates mixed infections rapidly because of its unusual solubility in acid urine common to bacterial invasion of the urinary tract. No renal damage, concretions or anuria.

...and when Spasmolysis is essential

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—the dual activity of SULFID with the well-known antispasmodic effect of natural belladonna alkaloids.

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COLUMBUS PHARMACAL COMPANY COLUMBUS 16, OHIO

cal Association and recipient of the OSMA 50-Year Award; member of the American Medical Association. Dr. Longbrake practiced a total of 62 years, most of that time in his native Marysville. He was active in many community affairs; was a member of the Masonic Lodge and the Methodist Church. He served on the local board of education and formerly was county coroner. Surviving are his widow and two daughters.

Joseph L. Pater, M. D., Hamilton; St. Louis University School of Medicine, 1930; aged 52; died September 30; member of the Ohio State Medical Association, the American Medical Association and the Pan-American Association of Ophthalmologists. Dr. Pater practiced medicine in Hamilton from 1932 to the time of his death, with time out for service in the Army Medical Corps during World War II. He was a member of the Catholic Church and the Knights of Columbus. Surviving are his widow, a son and a daughter.

Richard T. Pillsbury, M. D., Cleveland; resident physician at the Cleveland Metropolitan General Hospital, aged 25; died October 26; as the result of a boating accident.

Emmet J. Riordan, M. D., Portsmouth; University of Kansas School of Medicine, 1941; aged 43; died November 4; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons. Dr. Riordan had been practicing in Portsmouth since 1954. During World War II he served as Naval flight surgeon and again during the Korean Conflict he served in the Pacific theater. He was a member of the Catholic Church and the Knights of Columbus. Survivors include his widow, three sons, a sister and two brothers.

C. H. Skeen, M. D., Columbia, S. C.; Ohio State University College of Medicine, 1916; aged 65; died October 18; former member of the Ohio State Medical Association. A native of Greenfield, Dr. Skeen practiced there from 1938 to 1948. He previously practiced in Napoleon and Cincinnati. In recent years he became associated with the Veterans Administration and was on the staff of the VA Hospital at Bellingham, Wash., before moving to the VA Hospital in Columbia. A veteran of World War I, he was a member of the American Legion. Surviving are his widow, two sons, three daughters and two sisters.

Carl E. Stein, M. D., Loudonville; Ohio State University College of Medicine, 1932; aged 52; died October 20; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Dr. Stein was a practicing physician in Loudonville for 21 years, interrupting his service there for service in the Army Medical Corps during World War II. He was a member of the American Legion, the VFW, several Masonic bodies, the Eagles Lodge and the Temple. He is survived by his widow, two sisters and three brothers.

Clinton G. Stewart, M. D., Circleville; Rush Medical College, 1912; aged 85; died November 1; member of the Ohio State Medical Association and the American Medical Association. Dr. Stewart practiced in Circleville from 1916 until his retirement in 1952. An ardent golfer, he established the Stewart Cup which is awarded in the Pickaway Country Club each year. Surviving are his widow and a sister.

John W. Viktoryn, M. D., Cleveland; Western Reserve University School of Medicine, 1932; aged 51; died October 22; former member of the Ohio State Medical Association. A native of Cleveland, Dr. Viktoryn served all of his professional career there with the exception of time served in the Army Medical Corps during World War II. He was a member of the Catholic Church and the Holy Name Society. Surviving are his widow, two daughters and two sons.

Harry Ernest Woodbury, M. D., Akron; Western Reserve University School of Medicine, 1915; aged 71; died November 3; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Dr. Woodbury practiced in Akron for 40 years, with time out for service in the Army Corps during World War I. During the second World War he was a member of the Ohio National Board. He was a member of several Masonic bodies, the Episcopal Church and the Canton Skeet Club. Survivors include his son, Dr. Jefferson C. Woodbury, also of Akron; also three sisters and two brothers.

Chicago Medical Society To Present Its Annual Conference in March

The Chicago Medical Society's Annual Clinical Conference, to be held March 2, 3, 4 and 5 at the Palmer House, Chicago, will present a program encompassing both "breadth and depth," announced Dr. Coye C. Mason, chairman of the executive committee. Ohio physicians who wish additional information on this traditional postgraduate program are invited to write: Chicago Medical Society, 86 East Randolph Street, Chicago 1, Illinois.

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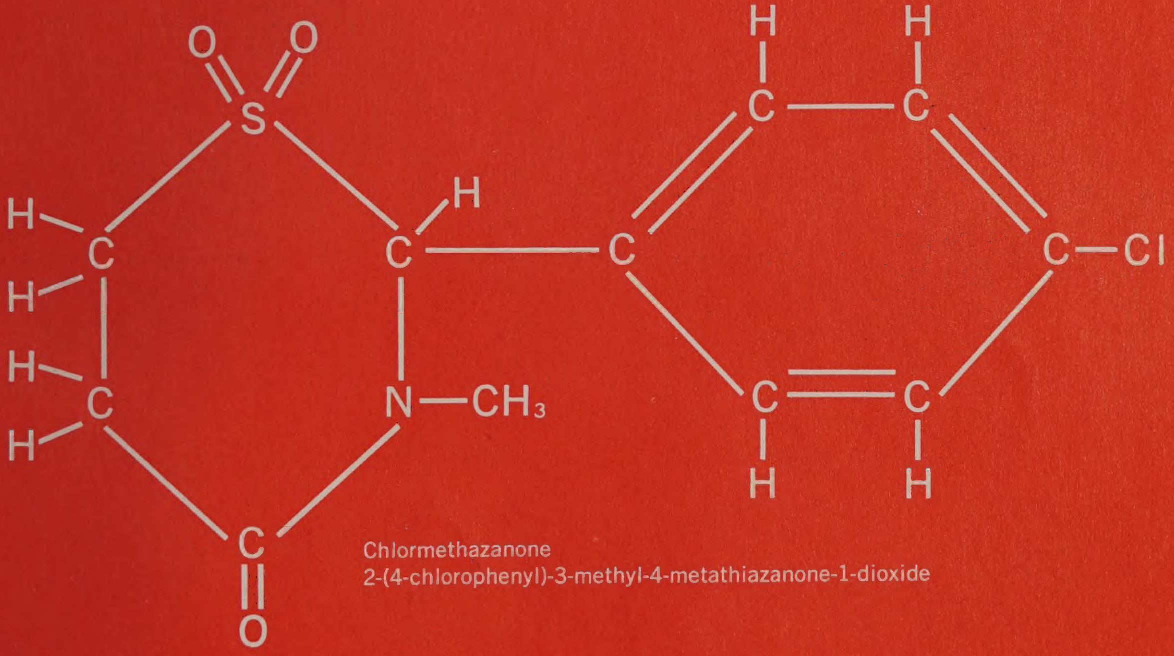
BRAND OF CHLORMETHAZANONE

a completely new major chemical contribution to therapeutics



Chlormethazanone
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unrelated chemically to any other drug in current use *designed to be equally effective as __both__*

a MUSCLE RELAXANT

a TRANQUILIZER

Trancopal

*the first true "TRANQUILAXANT"**

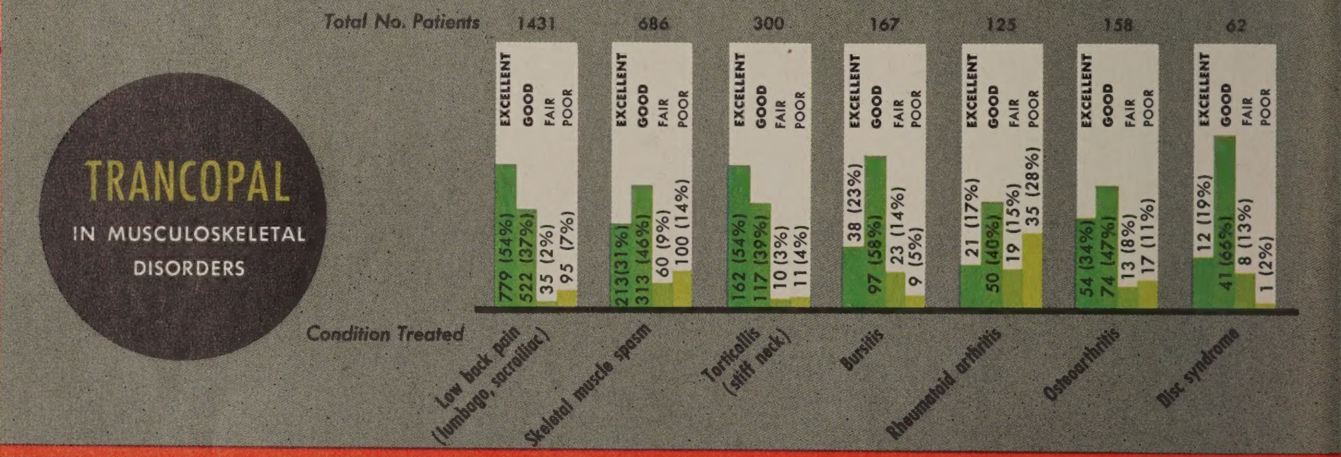
offering new freedom for your patients... from muscle spasm,

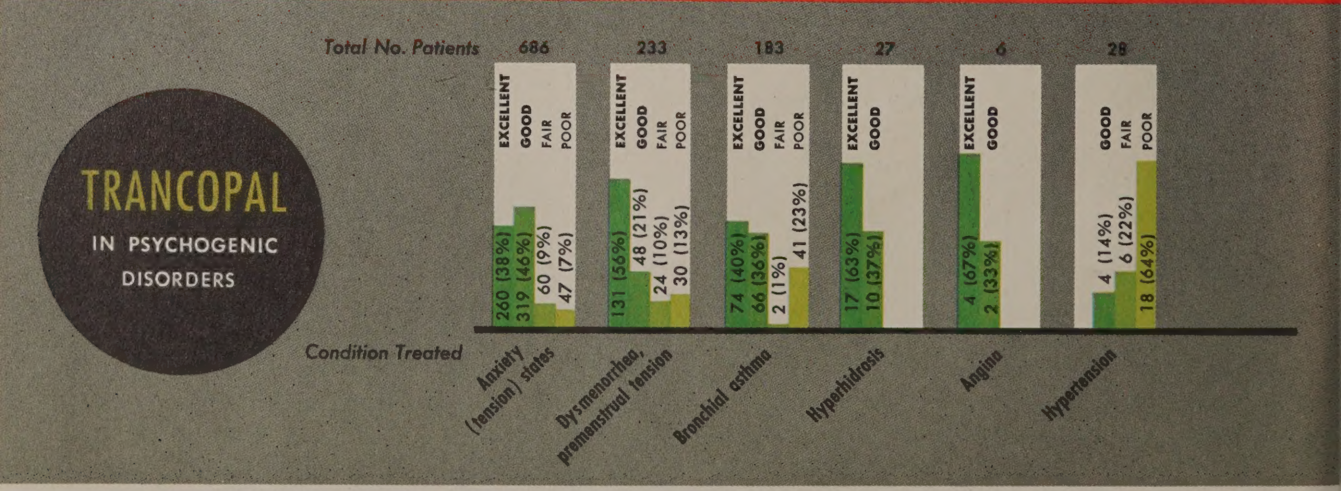
from tension and anxiety, from side effects

* **tran-qui-lax-ant** (tran'kwi-lak'sant) [< L. __tranquillus__, quiet; L. __laxare__, to loosen, as the muscles]

EXCEEDS OLDER DRUGS UP TO 4 TIMES IN PERCENTAGE OF CLINICAL EFFICACY (Lichtman)

The results of clinical studies of over 4000 patients by 105 physicians demonstrate that TRANCOPAL often is effective when other drugs have failed. From these studies it is clear that TRANCOPAL probably can provide more help for a greater number of ense, spastic, and/or emotionally upset patients than any other chemotherapeutic agent in current use.





TRANCOPAL . . . the first true "tranquilaxant"

Both a muscle relaxant and a calmative agent.

In musculoskeletal disorders, 91 per cent effective.

In anxiety and tension states, 93 per cent effective.

Lower incidence of side effects than with zoxazolamine, methocarbamol or meprobamate.

No known contraindications. Blood pressure, pulse rate, respiration and digestive processes unaffected by therapeutic dosage. No effects on hematopoietic system or liver and kidney function.

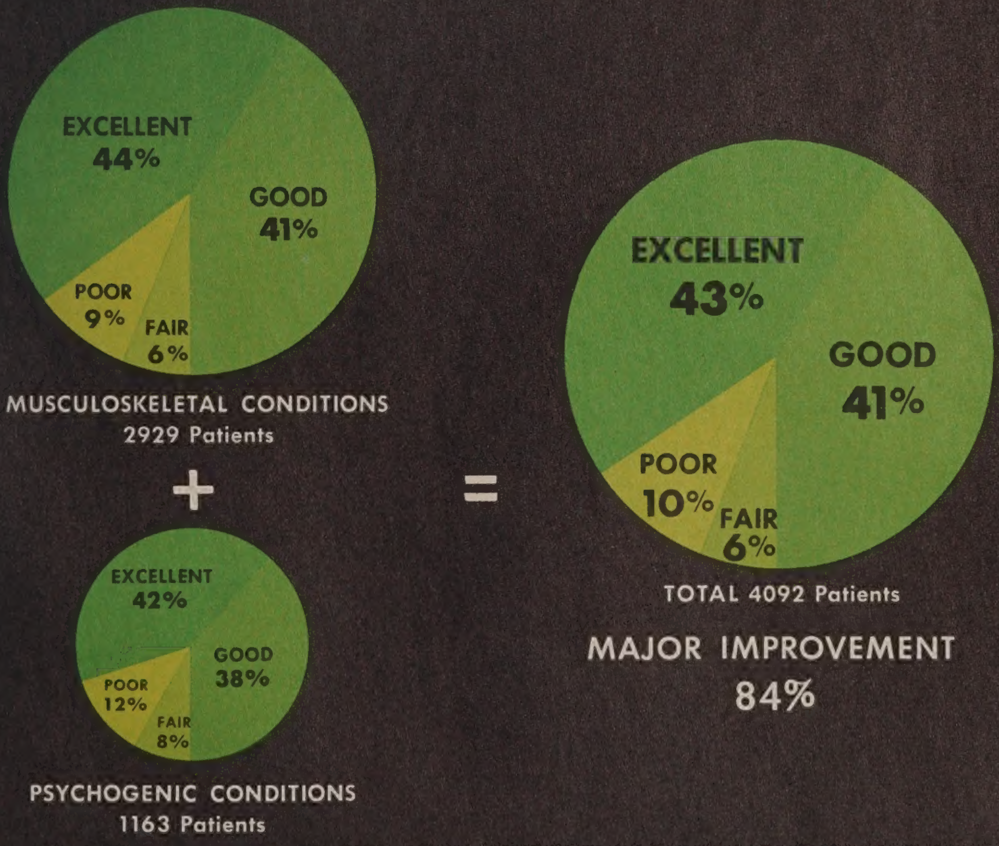
Low toxicity. In animals, even less toxic than aspirin.

No gastric irritation. Can be taken before meals.

No clouding of consciousness, no euphoria or depression.

No perceptible soporific effect, even in high dosage.

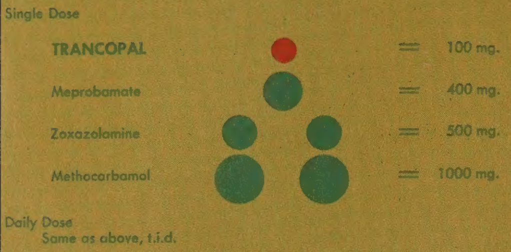
CLINICAL RESULTS IN 4092 PATIENTS



MAJOR IMPROVEMENT
84%

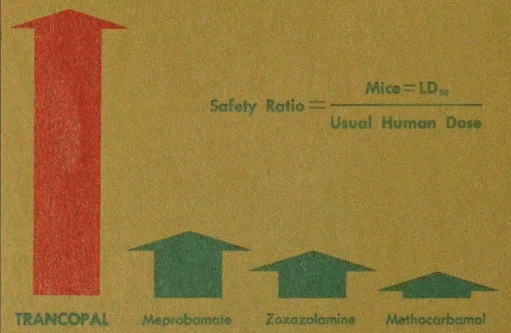
Compare Trancopal with 3 widely used central relaxants

FOR ACTIVITY



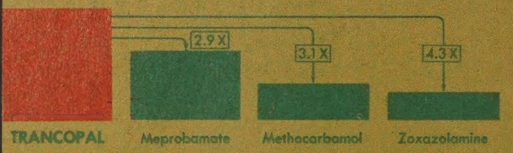
Considering the usual human dose, Trancopal, the first true "tranquilaxant," is four to ten times as potent per milligram.

FOR SAFETY



Comparative pharmacologic tests showed that Trancopal is up to thirteen times as safe, or up to thirteen times less toxic. The measure of safety was the LD_{50} in mice/usual human dose.

FOR CLINICAL EFFECTIVENESS



A clinical comparison in low back pain, torticollis, bursitis and anxiety states showed that Trancopal is up to four times as effective. Each of 40 patients received all four drugs in random rotation for several days. While each of the four drugs gave some relief, only the one providing the most effective relief was recorded.

INDICATIONS

Musculoskeletal
- Low back pain (lumbago)
- Neck pain (torticollis)
- Bursitis
- Rheumatoid arthritis
- Osteoarthritis
- Disc syndrome
- Fibrositis
- Joint disorders (ankle sprain, tennis elbow, etc.)
- Myositis
- Postoperative myalgias

Psychogenic
- Anxiety and tension states
- Dysmenorrhea
- Premenstrual tension
- Asthma
- Emphysema
- Angina

Neurologic
- Muscle spasm in paralysis agitans, multiple sclerosis, hemiplegia, poliomyelitis

TRANCOPAL thoroughly evaluated clinically

"In the treatment of conditions associated with skeletal muscle spasm there was a high percentage of satisfactory results (excellent, good or fair) in 310 patients (94%) out of 331 treated. . . . In 120 patients with simple anxiety or tension states results were satisfactory in 114 (95%). Dosage of chlormethazanone in all cases was 100 mg. t.i.d. As well as relieving the anxiety or tension state, chlormethazanone also allowed these patients to resume their usual occupations." (Lichtman)

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the first true "TRANQUILAXANT"

Dosage: One Caplet (100 mg.) orally three or four times daily. Relief of symptoms occurs in fifteen to thirty minutes and lasts from four to six hours.

Supplied: Trancopal Caplets® (scored) 100 mg., bottles of 100.

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• Baker, A. B.: Modern Med. 26:140, April 15, 1958. • Cohen, A. I.: In preparation. • Cooperative Study, Department of Medical Research, Winthrop Laboratories. • Gesler, R. M., and Coulston, F.: Toxicol. & Appl. Pharmacol. To be published. • Gesler, R. M., and Surrey, A. R.: J. Pharmacol. & Exper. Therap. 122:24A, Jan., 1958. • Gesler, R. M., and Surrey, A. R.: J. Pharmacol. & Exper. Therap. 122:517, April, 1958. • Lichtman, A. L.: Kentucky Acad. Gen. Pract. J. 4:28, Oct., 1958. • Surrey, A. R.; Webb, W. G., and Gesler, R. M.: J. Am. Chem. Soc. 80:3469, July 5, 1958.

Printed in U. S. A. 11-58 (3928)

Medical Education Fund Benefits from Unusual Business Firm Gift

The Nation's medical schools will this Christmas benefit from a new and unusual type of corporate giving.

In previous years, the Carling Brewing Company of Cleveland sent to its 600-odd distributors individual Christmas presents, whose total cost was about $10,000. This year no individual presents will be sent, but instead that entire sum will be given to the National Fund for Medical Education to be distributed among the medical schools for use primarily in supplementing faculty salaries.

The $10,000 contribution for medical education from Carling's will actually be worth $20,000 because the Ford Foundation matches all "new" money dollar for dollar, given to the National Fund.

The National Fund for Medical Education, founded in 1949 by Dwight D. Eisenhower, then president of Columbia University, former President Herbert Hoover, Dr. James B. Conant and other leading educators, channels contributions from American Industry to the medical schools in the form of unrestricted grants. Since the first grants were made in 1951, it has distributed $15,843,716 to these institutions.

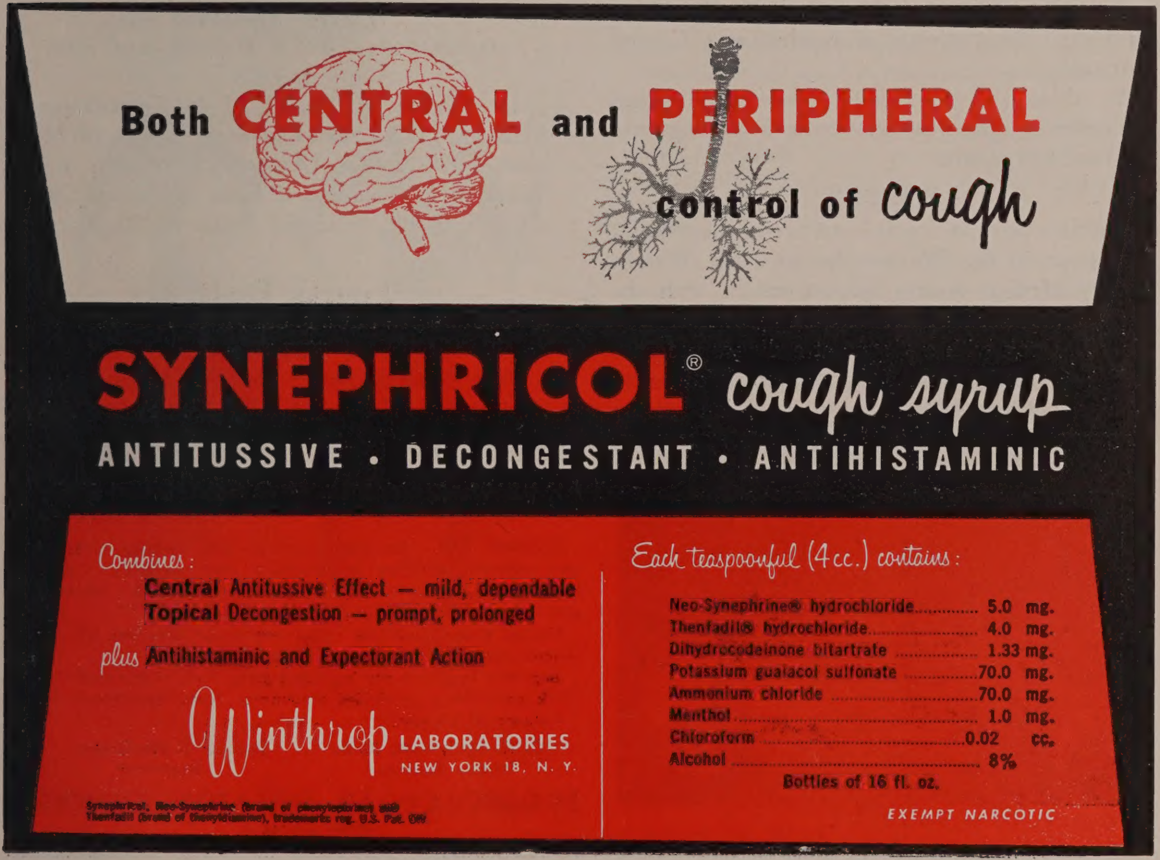
Carling's contribution in behalf of its distributors is over and above their regular annual donation. The company has supported NMEF since 1954.

Congress on Medical Education and Licensure, Chicago, Feb. 7-10

"Specialism in Medicine" will be the theme of the first plenary session when the 55th Annual Congress on Medical Education and Licensure convenes at the Palmer House in Chicago, February 7-10. Following several discussions on the theme, a series of workshop-conferences will focus on specialism in graduate clinical training.

Other session themes will be: "The Role of Research in the Education of all Physicians"; and "The Role of Medical Education in Civilian and Defense Mobilization."

Sponsors of the congress are The Council on Medical Education and Hospitals of the AMA, Advisory Board for Medical Specialties and the Federation of State Medical Boards of the U. S.



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SYNEPHRICOL® cough syrup

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Combines:

Central Antitussive Effect — mild, dependable

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Synephricol, Neo-Synephrine (brand of phenylephrine) and Thenfadil (brand of thenyldiamine), trademarks reg. U.S. Pat. Off.

Each teaspoonful (4 cc.) contains:

Neo-Synephrine® hydrochloride	5.0 mg.
Thenfadil® hydrochloride	4.0 mg.
Dihydrocodeinone bitartrate	1.33 mg.
Potassium guaiacol sulfonate	70.0 mg.
Ammonium chloride	70.0 mg.
Menthol	1.0 mg.
Chloroform	0.02 cc.
Alcohol	8%

Bottles of 16 fl. oz.

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Activities of County Societies . . .

First District

(COUNCILOR: CHARLES W. HOYT, M. D., CINCINNATI)

CLINTON

Members of the Clinton County Medical Society heard a discussion on investments, securities and estate planning at their luncheon meeting at the General Denver hotel Tuesday (October 7). Raymond Munger of Dayton, in trust planning and insurance business, spoke to the group.

The talks on health given annually at Wilmington high school by doctors were discussed. Doctors plan to continue the series of talks at the school.—Excerpts from the *Wilmington News Journal.*

HAMILTON

The subject of "Hypnotism" was discussed by a visiting panel at the October 7 meeting of the Academy of Medicine of Cincinnati. The panel consisted of Dr. Maurice E. Bryant, Colfax, Wash.; Dr. Milton H. Erickson, Phoenix, Arizona; and Dr. William T. Heron (Ph. D.), Minneapolis, Minnesota.

At the November 11 meeting the subject was "The Hormones of the Posterior Pituitary Gland," presented by Vincent du Vigneaud, Ph. D., Nobel Laureate 1956, professor of biochemistry, Cornell University.

In addition to the regular Academy programs, a number of specialty societies held meetings and conducted programs.

WARREN

For fifty years of devoted practice of the medical profession in the Waynesville area, the Warren County Medical Society in cooperation with the Ohio State Medical Association presented Dr. Mary L. Cook with a plaque at a dinner program at the Golden Lamb, Lebanon, on Wednesday evening (October 22). The presentation for the State Association was made by Dr. Charles M. Hoyt, Cincinnati, Councilor for the First District. Dr. Howard Berninger, president of the local Society, presided.

Ross H. Hartsock, president of the Waynesville National Bank, and a life-long friend of Dr. Cook, spoke in behalf of her friends and neighbors who presented her with 50 gorgeous red roses as a token of their love and esteem. Mr. Hartsock recounted many interesting incidents in the long practice of Dr. Cook.—Excerpts from the *Western Star,* Lebanon.

Second District

(COUNCILOR: R. DEAN DOOLEY, M. D., DAYTON)

CLARK

Dr. Harry Nieman, of Dayton, spoke on "A Survey of 200 Consecutive Cases of Skin Cancer," at a meeting of the Clark County Medical Society in Springfield on October 20.

DARKE

Dr. Norbert Kosater, Dayton, discussed the subject, "Hypnotism in General Practice," at the October 21 dinner meeting of the Darke County Medical Society in Greenville.

Third District

(COUNCILOR: FLOYD M. ELLIOTT, M. D., ADA)

ALLEN

Dr. Thomas E. Shaffer, of the Department of Pediatrics, Ohio State University School of Medicine, spoke at the October 21 meeting of the Academy of Medicine of Lima and Allen County on the subject, "Current Status of Staphylococci Infections."

Fourth District

(COUNCILOR: PAUL F. ORR, M. D., PERRYSBURG)

FULTON

The Fulton County Medical Society met in Archbold on October 21. Dr. Paul F. Orr, Perrys-

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Founded 1903. Complete facilities for training retarded and epileptic children educationally and socially. Pupils per teacher strictly limited. Excellent educational, physical and occupational therapy programs.

Varied group activities under competent direction on our spacious grounds of 28 acres. Selected movies.

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COMPREHENSIVE CONTROL OF CONSTIPATION

PROVIDES SOFT STOOLS GENTLY STIMULATED TO EVACUATION

DOXINATE® with DANTHRON (Doxan)

— the original dioctyl sodium sulfosuccinate fecal softener combined with danthron, the non-irritating, non-habit forming laxative —

Comprehensive control of constipation with Doxan . . .

★ prevents fecal dehydration and gently stimulates the lower colon in functional constipation

★ synergistically provides, with a subclinical dosage, peristaltic action on a soft, "normal" intestinal content rather than on the hardened mass typical of constipation

★ results in soft stools gently stimulated to evacuation . . . and restores normal bowel habits

Doxinate with Danthron (Doxan) is supplied as brown, capsule-shaped tablets containing 60 mg. dioctyl sodium sulfosuccinate and 50 mg. 1,8-dihydroxyanthraquinone.

Usual adult dose: One or two capsule tablets at bedtime. Bottles of 30 and 100.

When fecal softening alone is indicated— Doxinate 240 mg.—provides optimal once-a-day dosage for maintenance therapy.

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CINCINNATI 3, OHIO

burg, Councilor for the Fourth District, was present. It was decided to contribute $10.00 per member to the American Medical Education Foundation.

There was a discussion about the County Health Department and the tuberculin skin testing. Members discussed the possibility of doing pre-high school physical examinations and immunizations in the doctors' offices. A committee was appointed to discuss this problem.

The Society decided to sponsor a County-wide essay contest among high school students and offer a $25.00 prize for the best essay on "The Advantages of Private Medical Care."—R. A. Ebersole, M. D., Secretary.

LUCAS

Dr. F. William Sunderman, director of the Division of Metabolic Research, Jefferson Medical College of Philadelphia, was guest speaker for the Inter-Hospital Postgraduate Lecture Series on November 13 and 14. The theme of the series of lectures was "Biochemical Disorders in Disease."

Fifth District

(COUNCILOR: GEORGE W. PETZNICK, M. D., CLEVELAND)

ASHTABULA

Dr. Arthur Corcoran, Cleveland, addressed the Ashtabula County Medical Society on October 14. A member of the Cleveland Clinic staff, Dr. Corcoran spoke on the future of heart research, a subject on which he has made extensive study as chairman of the American Heart Association's committee on future needs and facilities for research.

CUYAHOGA

"Alcohol and Liver Disease," was the theme of the October 17 meeting of the Academy of Medicine of Cleveland, co-sponsored by the Cleveland Academy of General Practice. Following are phases of the subject discussed by respective members of a panel:

"Management of Alcoholism in Cirrhosis of the Liver," Dr. A. K. Bochner.

"Surgical Management of Patients with Cirrhosis of the Liver," Dr. Philip Partington.

"Medical Management of Patients with Cirrhosis of the Liver," George Gabuzda.

Moderator of the Panel was Dr. Oscar D. Ratnoff.

Following a social hour and dinner, Dr. Gerald Klatskin, professor of medicine, Yale University, spoke on the subject, "The Role of Alcohol in the Pathogenesis of Cirrhosis."

(Continued on Page 1662)

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GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, two weeks, Feb. 9, Mar. 16. Vaginal Approach to Pelvic Surgery, one week, Feb. 2, Mar. 9. General & Surgical Obstetrics, two weeks, Feb. 23, Mar. 30.

MEDICINE — Electrocardiography, Two - Week Basic Course, Mar. 16. Gastroscopy & Gastroenterology, two weeks, Mar. 2. American Board Review Course, one week, Apr. 20.

UROLOGY—Two-Week Intensive Course, Mar. 30. Ten-Day Practical Course in Cystoscopy, by appointment.

RADIOLOGY—Diagnostic X-Ray, two weeks, Mar. 2, Apr. 27. Clinical Uses of Radioisotopes, two weeks, May 4.

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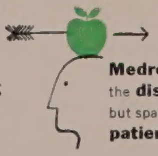
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Sixth District

(COUNCILOR: CARL A. GUSTAFSON, M. D., YOUNGSTOWN)

SUMMIT

A husband and wife team from Johns Hopkins School of Medicine, presented the scientific program for the November 4 meeting of the Summit County Medical Society in Akron. Dinner was served at the Akron City Club after which the meeting was held in the Akron City Hospital Auditorium. The subject discussed was hermaphroditism.

Seventh District

(COUNCILOR: ROBERT HOPKINS, M. D., COSHOCTON)

COLUMBIANA

Dr. Penn G. Skillern, Cleveland, was speaker at a meeting of the Columbiana County Medical Society on October 14 at the Hotel Wick in Lisbon. He discussed "Current Management of Diabetes."

Eighth District

(COUNCILOR: WILLIAM D. MONGER, M. D., LANCASTER)

FAIRFIELD

Fairfield County Medical Society members agreed at a recent meeting that one doctor each month would handle cases reported to the Well Child Clinic of the City Health Department in Lancaster.

Dr. Howard Sirak, on the staff of Children's Hospital, Columbus, spoke before the group discussing surgery as it pertains to rheumatic and congenital heart conditions.

The Society exhibited at the Fairfield County Fair. Dr. William Jasper, chairman of the Society's public relations committee, arranged an exhibit of antique medical and surgical equipment.

Tenth District

(COUNCILOR: E. H. ARTMAN, M. D., CHILLICOTHE)

FRANKLIN

Nearly 400 reservations were received for this year's "P. R. Institute for Medical Assistants" held Wednesday, October 8, 1958, at the Ohio Union, on the Ohio State University Campus.

Doctors Homer A. Anderson, George D. Clouse and Paul R. Leithart with Stanley R. Mauck, Executive Director of the Columbus Bureau of Medical Economics, as Chairman comprised the committee responsible for the program.

The theme of the meeting was "The Public Relations Factor in Telephone Communications" and featured three speakers. Dr. Thomas R. Curran discussed "The Use of the Telephone—as observed by the Professional Relations Committee" and was followed by Stanley R. Mauck on the subject "The Use of the Telephone—as observed by the Medical Bureau." The guest speaker for the evening was Miss Helen Kiess, Service Consultant for the Ohio Bell Telephone Company who presented an interesting and informative talk entitled "The Telephone—Friend or Foe." A lively question and answer session followed the program which highlighted some of the everyday problems encountered in the physician's office involving use of the telephone.—*Bulletin of the Columbus Academy of Medicine.*

Eleventh District

(COUNCILOR: H. T. PEASE, M. D., WADSWORTH)

ERIE

Dr. Samuel R. Gerber, Cleveland, coroner of Cuyahoga County, was speaker at a joint meeting of the Erie County Medical Society and the Auxiliary at the Ontario School. Dr. Gerber spoke on the subject, "Automotive and Traffic Safety."

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1. Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. **166**:1019, March 1, 1958. 2. Current personal communications; in the files of Wallace Laboratories.

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Representatives of other groups in the area interested in safety were present.

LORAIN

The regular meeting of the Lorain County Medical Society was held Tuesday, October 14, at Oberlin Inn, preceded by a social hour and dinner. The program of the evening was given by Dr. George J. Thomas, director of the Department of Anesthesiology, St. Francis Hospital, Pittsburgh, Pa., who gave an excellent lecture and demonstration on "Hospital Hazards," alerting all to the necessity for constant vigilance to assure safety in anesthetizing areas.

In recognition of their interest in this subject, area hospital administrators, fire chiefs, operating room supervisors and nurse anesthetists were invited as guests of the Society, and welcomed and introduced by Dr. Ben V. Myers, president. Fifty physicians and 20 guests were present.

In the regular meeting prior to the lecture, Charles C. Brausch, M. D., of Avon Lake, was elected to Associate Membership, and Iwan Czornyj, M. D., of LaGrange, elected to Active Membership.

Dr. Valloyd Adair gave a memorial address for the late Charles R. Meek, M. D., of Lorain, and the group paid a standing silent tribute to his memory.

Reports were given by Paul J. Kopsch, chairman of Legislative Committee; John W. Wherry, chairman of Insurance Committee; and Ben V. Myers on behalf of O. H. Schettler, chairman of Committee for Liaison with County Welfare, and Joseph M. Strong, Social Committee chairman, responsible for the recent clambake.

Dr. H. T. Pease, councilor of the eleventh district, was welcomed by the Society, and reported on various matters of interest.

Dr. Ben V. Myers announced the members of the New Education Committee. James T. Stephens of Oberlin has consented to be chairman, with Roy E. Hayes (Elyria), Charles Butrey (Lorain), John R. Bay (Oberlin) and William Wladecki, Elyria).

The Nominating Committee was appointed to prepare a slate of officers for presentation at the November meeting. Dr. James T. Stephens will serve as chairman, with T. L. Smith and R. D. Berkebile.—Lawrence C. Meredith, M. D., Secretary-Treasurer.

Orthopaedic Society

A meeting and program has been scheduled by the Ohio Orthopaedic Society to be held in Akron, April 10 and 11, 1959. Further details will be announced. Committee on arrangements may be contacted by writing James G. Roberts, M. D., 655 W. Market St., Akron 3, Ohio.

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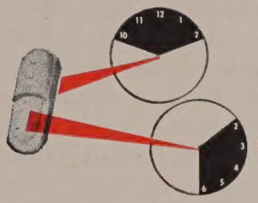

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Medicare Office Issues Policy Regarding Special Permit

The Washington office of Medicare on October 21 issued the following statement of policy regarding Medicare Permits:

Inquiries have been received as to whether an eligible dependent who commences receiving authorized care from a civilian source participating in the program, who is *residing apart from the sponsor* at the time the care commences, and who *takes up residence with the sponsor* before completion of that care, may continue that care from that source without obtaining a Medicare Permit. As a general rule, such care may be continued without a Medicare Permit. Guidance for administration of the rule in certain specific instances is set forth below:

a. An eligible dependent spouse or child who is *hospitalized* for care authorized under the program, who is "Residing Apart from Sponsor" at the time of admission, and who acquires the status of "Residing with Sponsor" during hospitalization, may complete authorized hospital care for that admission and for readmissions indicated under Section 5-506g of the Joint Directive without a Medicare Permit. That Section covers readmissions within 14 days following discharge from the previous admission, for authorized treatment of the original condition for which initially hospitalized, or direct complications thereof.

b. An eligible dependent who is "Residing Apart from Sponsor" at the time *maternity care* is commenced, and who takes up residency with her sponsor during the period of the care and prior to hospitalization for delivery or for complications of pregnancy, would not be in a position to certify on the hospital claim form "Residing Apart from Sponsor—Yes." Also, she would not be in a position to make such a certification on claim forms of other approved sources of care. However, if she does not change her attending physician, she may obtain required hospitalization and other required care from approved sources without a Medicare Permit, provided the person signing Item 14 on the DA Form 1863 furnishes the hospital a written statement, on the claim form or attachment thereto, that maternity care for the pregancy or complications thereof for which hospitalized was commenced on a date when she was residing apart from the sponsor. If such an eligible dependent changes her attending physician for any reason (other than death or illness of her attending physician), she must secure a Medicare Permit in order to obtain authorized care from civilian sources at Government expense. In those instances where a change of attending physician has occurred due to the death or illness of the attending physician, that fact should be stated on the claim form or attachment thereto by the person signing Item 14 on the DA Form 1863. Of course, any eligible dependent may obtain required care from a uniformed services medical facility, if available.

Nine Steps To Curb Staph Infections in Hospitals

On the basis of findings and recommendations of the National Conference on Staphylococcal Disease held in Atlanta, the following measures are proposed by the Public Health Service to prevent and control hospital outbreaks:

1. Establish infectious control committees in all hospitals.

2. Employ an "infection log" for entering and classification.

3. Screen staff personnel who have boils or who are carriers.

4. Exercise discrimination in use of antibiotics.

5. Store cultures from staph infections.

6. Isolate infectious patients.

7. Take special precautions in nurseries for newborn.

8. Stress training of personnel, intensively and continuously.

9. Strengthen laboratory services and expand research.

Youngstown Physician Is Honored By Jaycees for Community Service

Dr. John N. McCann, Youngstown, active civic, religious and medical leader, was presented the Sixth Annual Frank Purnell Award by the Junior Chamber of Commerce Tuesday night (Oct. 28).

Dr. McCann was honored at the Jaycee's 24th annual Bosses' Night Dinner at Hotel Pick-Ohio, attended by more than 300 industrial, business and civic leaders.

Among Dr. McCann's outstanding contributions to Youngstown and vicinity, have been service to the YMCA, Youngstown University, the Mahoning County Tuberculosis Hospital, St. Elizabeth Hospital and many Youngstown Diocese Catholic charities.

Dr. McCann is president of the Ohio State Medical Board and is a member of the executive committee of St. Elizabeth Hospital. He has been a board member 25 years of the YMCA and is serving on the board of trustees of Youngstown University.—Excerpt from the *Youngstown Vindicator.*

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Activities of Woman's Auxiliary . . .

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(See Page 1541 for roster of officers.)

ALLEN

Lima and Allen County Medical Auxiliary was hostess to the Third District of Ohio at a luncheon meeting on October 22 at the Lima Club. Mrs. Charles Blumstein, President, introduced Mrs. Stephen Churchill of Kenton, Third District Director, who in turn presented the following state and district officials: Mrs. Rivington Fisher of Columbus, Tenth District director; Mrs. L. W. Sontag, Yellow Springs, State Public Relations director; Mrs. R. D. Hendrickson of Xenia, Second District director; Mrs. G. T. Harding III of Worthington, state first vice-president; Mrs. C. H. Bell of Mansfield, state president.

Mrs. Bell was the main speaker of the afternoon. Mrs. H. C. Kingsbery is Program Chairman.

COSHOCTON

The annual meeting of the Seventh District of the Woman's Auxiliary of the Ohio State Medical Association was held October 14 at the Town and Country club, with the Woman's Auxiliary of the Coshocton County Medical Society as hostess.

Following the luncheon Mrs. Norman L. Wright, president of the local group, greeted the guests. A musical program was presented by Mrs. Olan Aughbaugh.

Mrs. C. F. Goll, Steubenville, District director, introduced the state officers and presidents of Jefferson, Tuscarawas and Coshocton counties.

Mrs. C. H. Bell, state president, reviewed the national convention held in June in Los Angeles. She emphasized the priority projects for the year, and concluded with the national slogan, "Safeguard Today's Health for Tomorrow."

Mrs. Floyd W. Craig was chairman for the luncheon.

ERIE

The Woman's Auxiliary to the Erie County Medical Society had its first meeting September 15. The Auxiliary members were luncheon guests at the home of Mrs. C. E. Swanbeck, Huron. Mrs. Swanbeck, a past-president, is Erie County's representative in the Ohio Legislature and a member of the house committee on Education, Welfare, Commerce and Transportation.

The luncheon was served in authentic Swedish style, and in the same manner that Dr. and Mrs. Swanbeck enjoyed on their recent tour of the Scandinavian countries. During her trip she surveyed government bodies, common problems in geriatrics, education, housing and retarded children, as compared to those of the U. S. After the luncheon, Mrs. Swanbeck gave a most interesting talk concerning these problems.

The October meeting of the Woman's Auxiliary to the Erie County Medical Society was a joint meeting with the Erie County Medical Society. The speaker was Dr. S. R. Gerber, Cleveland, coroner of Cuyahoga County, who spoke on the subject "Automotive and Traffic Safety." Safety is being stressed by the Ohio State Medical Association and all county auxiliaries were asked to cooperate in giving a program of this type. Special invitations were issued to interested persons and organizations. These included, AAA, city and county High School driver's trainer clubs, sheriff of Erie County, highway patrol, safety director in all service clubs, county coroner and assistants, police chief, newspaper and radio representatives. Refreshments and a social hour followed.

The public relations committee offered as a public service the processing of absentee ballots to persons physically unable to go to the polls on election day.

FAIRFIELD

The Woman's Auxiliary to the Fairfield County Medical Association was invited to the home of Mrs. William Boswell, Baltimore, for a luncheon meeting.

Mrs. G. F. Jones, president of the group, presided for this business meeting.

A statement was presented by Mrs. William Jasper in regard to the transportation for student nurses from Lancaster-Fairfield Hospital to the Branch College for affiliate work. Auxiliary members have been providing this transportation in private cars. The Auxiliary agreed to provide funds for commercial mode of transportation, as an emergency measure.

Mrs. F. A. Dowly reported that recreational facilities and equipment authorized by the Woman's Auxiliary had been provided for the student nurses.

Mrs. C. R. Reed was chairman for the annual Halloween party for the student nurses.

Social Hour followed the business session. Mrs. Oscar Jepson, honorary member, and Mrs. C. B. Crow, prospective member, were guests at this meeting.

FRANKLIN

The Woman's Auxiliary to the Columbus Academy of Medicine had a luncheon meeting on

October 20 in St. Stephen's Episcopal Church, Columbus.

Dr. Lloyd M. Parks, dean of the College of Pharmacy, Ohio State University, was the speaker. His topic was "The Dangers of Self Medication."

Presidents and Medical Auxiliary members of the Tenth District from Delaware, Fayette, Franklin, Knox, Madison, Morrow, Pickaway, Ross and Union counties were invited to attend. Special guests included Mrs. C. H. Bell, Mansfield, state president; Mrs. C. A. Colombi, Cleveland, state president-elect; and Mrs. Karl F. Ritter, Lima, state chairman, American Medical Education Foundation. Mrs. Rivington Fisher, Columbus, is the director of the Tenth District.

Mrs. Nicholas Michael, social committee chairman, was assisted by Mrs. I. Darin Puppel, Mrs. M. L. Phillips, Mrs. Jack Tetirick, Mrs. Albert Kostoff, Mrs. Ralph Johansmann, and Mrs. James Hardie.

An Executive Board meeting was held in the Church Lounge. Mrs. George O. Kress, president, presided.

HAMILTON

The Woman's Auxiliary to the Academy of Medicine of Cincinnati met on November 3. Once again the Auxiliary did a splendid job with its Disabled Voters Committee. Thirty-five auxiliary notaries voted approximately 250 patients in 8 Cincinnati Hospitals. Mrs. James B. Street, Vice-Chairman of this committee, carried on in the absence of the chairman, Mrs. William C. Schmidter.

In November the local Auxiliary held its annual dinner dance for the benefit of the philanthropic fund. "The Harvest Moon Ball" was held in the Pavillon Caprice of the Netherland Hilton Hotel under the general chairmanship of Mrs. William P. Jennings. Cocktails preceded dinner which was followed by dancing.

The sale of Christmas cards for the benefit of the AMEF is proceeding with great success under the chairmanship of Mrs. Robert B. Krone.

MAHONING

The Woman's Auxiliary to the Mahoning County Medical Society opened its Fall season with a luncheon at Squaw Creek Country Club on Sept. 9. Mrs. Earl H. Young presided.

Mrs. Myron Hanysh, membership chairman, welcomed 13 new members. The guest speaker was Father Anthony of Saints Peter and Paul Church who reviewed Tito's rise to power in Yugoslavia.

An Auxiliary bowling league has been organized with Mrs. Edward A. Shorten as chairman.

Members of the Auxiliary acted as hostesses

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Two weeks—
Part time .... October 1 and April 1

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Full Time—
One Week .... November 1 and May 1

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UROLOGY—INSTRUMENTAL AND OPERATIVE (CADAVER)
Four weeks—
Full time .... October 1 and April 1

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THE DEAN, 345 West 50th Street,
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when the Mahoning County Medical Society staged its commemoration banquet September 27 honoring 27 past-presidents. Two hundred doctors and their wives attended. The speaker was Dr. George F. Lull, assistant to the president of the American Medical Association, who urged physicians to take a more active part in community problems.

"Chapeaux for You" was the title of the millinery style show presented at the October 7 luncheon meeting at the Jade Room for Auxiliary members and their guests.

MUSKINGUM

A meeting of the Eighth District Medical Academy Auxiliary was held October 2, at the home of Mrs. William B. Smith. Fifty-two members attended a tea which was followed by adjournment to the Zanesville Country Club. At the club Mrs. James Morton, president of the local auxiliary, introduced three visiting officers of the Ohio Auxiliary: Mrs. C. H. Bell of Mansfield, Mrs. George T. Harding III of Worthington, and Mrs. J. R. Wells of Newark. Entertainment followed which was a farce fashion show given by members of the Muskingum County Medical Auxiliary. The women then joined their husbands, who had been spending the day at the Academy District meeting in Zanesville, for dinner. The dinner was highlighted by a talk "Unsolved Murders" given by Dr. Alan Moritz from Western Reserve University.

OTTAWA

The Auxiliary to the Ottawa County Medical Society has already accomplished many feats.

During the Oak Harbor Fair and Fall Festival the Auxiliary had a Health Booth. Our members took turns staffing the booth and giving to the public free Health Record books, wallet cards, and samples of *Today's Health.*

October 21 a rummage sale was held in Port Clinton, the proceeds of which will be used for projects of the hospital.

October 28 the annual Nurse Recruitment Tea was given. All sophomore girls of the county were invited. This year the film "Helping Hands for Julie," was shown to interest students in the opportunities and rewards of careers in nursing and the allied professions.

On October 31 members of the Auxiliary took Halloween favors to the hospital and to a county nursing home.

RICHLAND

The Woman's Auxiliary to the Richland County Medical Society met for a meeting and tea at the Women's Club, Mansfield. Forty-three members were present.

Mrs. Robert Tawse stated that a student nurse at Mansfield General Hospital had need for and was now using the Auxiliary sponsored scholarship. She also stated that the Future Nurses Club looks most promising with 28 members present at the last meeting.

Reports from the State Conference meeting held in Columbus, and from the District Meeting held in LeRoy, were given.

After all business was taken care of the meeting was turned over to Mrs. Charles Butner who acted as Mistress of Ceremonies for the program that followed in honor of Mrs. C. H. Bell, the State Auxiliary President.

Mrs. J. L. Stevens told of the early formation of the local and state auxiliary and gave a few highlights of the year she was State Auxiliary president.

The meeting was adjourned by Mrs. Butner and a tea followed.

STARK

Twenty new members of the Woman's Auxiliary to the Stark County Medical Society were present at a tea October 14 at the home of the president, Mrs. Ralph K. Ramsayer. Mrs. Richard Skibbens, membership chairman, was in charge of the arrangements and introduced the new members to the auxiliary board. Mrs. Richard Spitzer, immediate past-president, and Mrs. Lloyd Dowell of Massillon, president-elect, presided at the tea table.

The first meeting of the Auxiliary was held in Alliance at the Alliance Women's Club on October 21. Mrs. James J. Thomas was chairman of the meeting and Mrs. William A. McCrea, co-chairman. A musical program was given by Mrs. Cecil Stewart.

The Annual Benefit Dance sponsored by the Auxiliary for the benefit of the nurses' scholarship fund was discussed. The rotating scholarship for nurses was established by the auxiliary in 1937. Since that time 50 students have been given assistance in their nursing careers. The total value of the loans given students in area schools of nursing amounts to $13,680. These funds are raised primarily from the annual dance. The committee is headed by Mrs. Murray W. Scott, Jr., assisted by Mrs. J. George Tifft as co-chairman.

SCIOTO

The District 9 meeting of the Woman's Auxiliary to the Ohio State Medical Association was held in connection with the 18th birthday anniversary celebration of the Woman's Auxiliary of Scioto County Medical Society at the Elks City Club auditorium.

Mrs. George W. Cooper of Waverly, district director, presided at the afternoon luncheon at which past-presidents of the local group served as hostesses under the chairmanship of Mrs. Samuel L. Meltzer.

The state president, Mrs. C. H. Bell, of Mansfield, was the afternoon speaker.

Dr. Carter L. Pitcher, chairman of the state advisory committee to the auxiliaries and district Councilor of the Medical Association, and Dr. S. L. Meltzer, president of Scioto County Medical Society, also gave short talks.

The District 10 director, Mrs. Rivington Fisher of Columbus, also was a guest. County presidents attending included Mrs. Alvis Hambrick of Jackson, Mrs. Ralph Massey of Lawrence, Mrs. Robert Lever of Pike and Mrs. Armin Melior of Scioto.

The entertainment featured O. T. (Sandy) Dresbach, Mrs. F. Carl Deshler, Mrs. J. Edward Doerr and Mrs. Franklin Page, who presented "Behind the Scenes in Radio."

Grant Reed, president of Scioto County Cancer Society, presented Mrs. Daehler with an award of merit for extraordinary service in the crusade to conquer cancer.

SUMMIT

Sixth District Postgraduate Day Meeting was held in Akron on October 22. Mrs. John Brumbaugh was chairman of the committee to entertain the visiting wives, with Mrs. Robert G. McCready as co-chairman. The agenda began at 8 a. m. in the Sheraton Hotel with a continental breakfast served to the visitors as they arrived and registered.

Visitors and members of the Akron Auxiliary were entertained at luncheon at the Women's City Club with a program by Joe Portaro, hair stylist of Cleveland.

The day ended with a banquet for the doctors and wives in the Sheraton Hotel. Mrs. M. F. Bossart and Mrs. J. Walter Johnson, assisted by their committee, were in charge of reservations. The hostess committee was in charge of Mrs. Uffe Jensen.

Mrs. C. A. Colombi, president-elect of the Ohio State Medical Auxiliary, and Mrs. Edward Bauman, director of the Sixth District, presided at the business meeting.

The Woman's Auxiliary to the Summit County Medical Society held a brunch meeting at the Portage Country Club on November 4. Members and their guests heard a very interesting and enjoyable talk by Dr. Nicholas Dallas of Toledo, creator of Rex Morgan and Judge Parker.

TRUMBULL

The Auxiliary to the Trumbull County Medical Society met for lunch at the Squaw Creek Country Club on October 14. Miss Marie O'Rourke, dean of Girls at Harding High School in Warren, was

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the guest speaker. Her subject was "Preparing Your Child for College."

The short business session was conducted by the president, Mrs. John Grima. Attention was called to the District Meeting and to the radio program "Child Development," sponsored by the Auxiliary over the local radio station. Mrs. E. R. Westbrook, Mrs. L. A. Claitsman, and Mrs. E. G. Caskey took part in the radio program.

The Trumbull County Bar Auxiliary entertained the Medical Auxiliary at an evening meeting at the Warner Hotel on October 23. Margaret Spithaler spoke on the subject, "Do It Yourself." The Medical Auxiliary entertained their husbands at a Crazy Hat Square Dance on October 29. Mrs. J. E. Burns and Mrs. J. Williams were chairmen at this party.

National Conference on Aging Is Planned for Spring of 1959

Plans are currently being developed for a national conference on the health problems of the aged, to be held in the spring of 1959 under the sponsorship of the Joint Council for the Health Care of the Aged, Mrs. Florence L. Baltz, Washington, Ill., newly elected chairman of the Council, has announced.

"Such a conference will provide the basis for more effective joint planning on the part of those who are the principal purveyors of health care for the aged," Mrs. Baltz, incoming president of the American Nursing Home Association, pointed out.

The Joint Council was formed last April under the sponsorship of the American Dental Association, the American Hospital Association, the American Medical Association, and the American Nursing Home Association.

Its objectives are to (1) identify and analyze the health needs of the aged, (2) appraise available health resources for the aged, (3) develop programs to foster the best possible health care for the aged, (4) foster effective methods of payment for the health care of the aged, and (5) foster health education programs of the aged.

Twelve directors of the Joint Council, three from each of the four sponsoring organizations, were elected at an incorporation meeting held on October 25.

The new directors, in addition to Mrs. Baltz, are:

Dr. Louis M. Orr, Orlando, Fla., president-elect of the American Medical Association and vice-chairman of the Joint Council; Dr. Gunnar Gundersen, LaCrosse, Wis., president of the AMA; Dr. F. J. L. Blasingame, Chicago, executive vice-president of the AMA; Dr. W. R. Alstadt, Little Rock, Ark., president of the American Dental Association; Dr. Harold Hillenbrand, Chicago, secretary of the ADA; and Bernard J. Conway, Chicago, secretary of the ADA's Council on Legislation.

Others are: Tol Terrell, San Angelo, Tex., immediate past-president, American Hospital Association; Ray Brown, Chicago, AHA past-president; Dr. Edwin L. Crosby, Chicago, director of the AHA; Ira O. Wallace, New Castle, Ky., president of the American Nursing Home Association; and Frank C. Bateman, Washington, D. C., executive director, ANHA.

Howard I. Wells, Jr., executive secretary of the Joint Council, was elected secretary-treasurer.

Two Ohio Physicians and Layman Honored at Heart Meeting

An Ohio physician became president-elect of the American Heart Association at that organization's annual meeting, another Ohio physician was honored with a top award and an Ohio layman was named to a top executive post.

Dr. A. Carlton Ernstene, chief of staff of the Division of Medicine, Cleveland Clinic, was named president-elect of the American Heart Association at the Annual meeting in San Francisco. He will assume the office of president at next year's annual meeting, succeeding Dr. Francis L. Chamberlain of San Francisco. Dr. Ernstene was vice-president of the AHA for 1957-1958.

A past-president of the Ohio State Heart Association and of the Cleveland Area Heart Society, he has been a member of the AHA's board of directors since 1953 and has served as chairman of the Council on Clinical Cardiology and of the Policy Committee. A director of the American Society for the Study of Arteriosclerosis, Dr. Ernstene is also a member of the editorial board of *Circulation,* professional publication of the Heart Association. For several years Dr. Ernstene has been chairman of the Committee on Scientific Work for the Ohio State Medical Association, the committee which has charge of arrangements for the OSMA Annual Meeting.

Dr. Irvine H. Page, also of Cleveland, was awarded the 1958 Albert Lasker Award of the AHA for distinguished achievement in the field of cardiovascular research. The award to Dr. Page honors especially his many contributions to greater scientific understanding of hypertension and its underlying mechanisms.

Walter S. Page, Jr., of Columbus, executive director of the Ohio State Heart Association, was installed as president of the national Staff Conference of Heart Associations. The 800-member organization includes professional heart association workers from the United States and Canada.

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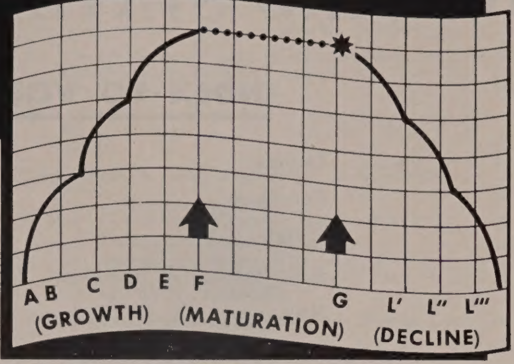

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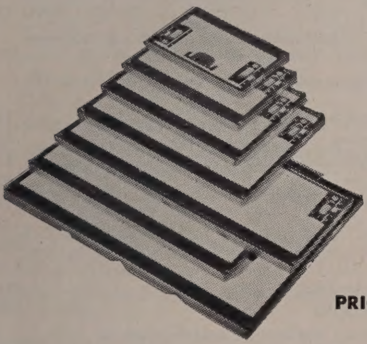

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Five Physicians on Ohio Committee To White House Conference

Five Ohio physicians have been appointed by Gov. C. William O'Neill to a 49-member committee to represent Ohio at the National White House Conference on Children and Youth in 1960.

They are: Dr. Thomas E. Shaffer, Columbus, chairman, Committee on School Health, Ohio State Medical Association; Dr. Robert C. Markey, Bowling Green, Wood County Health commissioner; Dr. Margot D. Hartmann, Columbus, chief, Division of Child Hygiene, Ohio Department of Health; Dr. Wendell A. Butcher, Columbus, assistant commissioner, Ohio Department of Mental Hygiene and Correction, in charge of the state's program for mentally retarded children; Dr. Claire M. Ness, director, Cleveland Guidance Center.

Other members of the committee include educators, legislators and leaders in child and youth activities throughout the state. The chairman is Harry T. Sealy, a vice-president of the Cleveland Electric Illuminating Company.

The Washington meeting stems from the Mid-Century White House Conference held in 1950 for delegates from all states and territories.

The Ohio committee is expected to meet next year to discuss juvenile problems and to draft recommendations for the national conference.

COMING MEETINGS

Ohio State Medical Association, 1959 Annual Meeting, April 21-24, Columbus.

American College of Physicians, Ohio Regional Meeting, Veterans Administration Hospital, Cincinnati, January 22.

Chicago Medical Society, Annual Clinical Conference, Palmer House, Chicago, March 2-5.

Congress on Industrial Health of the AMA, Netherland Hilton Hotel, Cincinnati, February 16 and 17.

Congress on Medical Education and Licensure, Chicago, February 7-10.

Institute on Industrial Health, and Department of Ophthalmology, University of Cincinnati, Industrial Eye Problems, March 9-12.

Institute on Steroid Therapy, Ohio State University, January 8.

Ohio Orthopaedic Society, Meeting, Akron, April 10, 11.

Ohio Society of Internal Medicine, Netherland Hilton Hotel, Cincinnati, January 21.

Veterans Administration, Series of Clinical Courses, Wednesday Evenings, Cleveland.

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Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 79 E. State St., Columbus 15. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

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FOR RENT: 4-Rm. Office Suite for physician in Fostoria, Ohio. Ground floor, 1½ blocks from Main St., near Post Office; parking for physician's car in rear; local 40-bed hospital municipally owned. K. S. Rowe, 225 W. Center St., Fostoria, Ohio.

OB-GYN, BOARD QUALIFIED, Graduate Milan, Italy, 1951; residencies Margaret Hague Maternity Hospital and Beth Israel Hospital, N. J.; Ohio licensed; married; wishes to join group or associate with established Ob-Gyn leading to partnership. Box 110, c/o Ohio State Medical Journal.

WANTED: General Practitioner, town of 1700 population, hospital facilities and office space available. Good community in which to work. Contact: Plymouth Chamber of Commerce, c/o Rev. R. F. Hall, 45 W. Broadway, Plymouth, Ohio.

DOCTOR, EXCELLENT OPPORTUNITY in Mt. Vernon, O. Two offices for rent on Public Square. Drs. moving to medical center. Good factory town. Two fine hospitals. Prescription town. Easy to get acquainted. Write Raymond A. Taugher, 32 E. High St.

PREVIOUS PHYSICIAN DECEASED. Doctor's office completely equipped and general practice of thirty years standing available. No monetary outlay necessary. Please contact Mrs. Bertha Stewart, 132 Edgerton Rd., Akron 3, Ohio.

FOR RENT or SALE: Physician's office and/or equipment; office located on ground floor within one-half block of Public Square in County Seat. Trading area of 11,000 people. General Practice; equipment includes x-ray—EKG. Contact Dr. E. Galen Rex, McConnelsville, Ohio, or phone No. 1851, McConnelsville, Ohio.

FOR SALE: A Sanborn Viso Cardiette Direct Writer Electrocardiograph. Instrument in excellent condition. Standard and Precordial chest leads. Price $250.00. Write or contact Charles H. Maly, M. D., Sardinia Medical Clinic, Sardinia, Ohio.

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WANTED: Associate in general practice. Double office in Medical Center. Located in Medina, Ohio. A pleasant place to live. Good schools, churches and an expanding hospital. Robert E. Smith, M. D., 750 E. Washington St., Medina, Ohio.

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General Chairman: Dr. Norman O. Rothermich
Date of Sessions: January 8, 1959—
9:00 A.M. to 5:30 P.M.
Place: Ohio Union (Ohio State University)
Subject: An Institute on Steroid Therapy which will be under the auspices of the Department of Medicine of Ohio State University School of Medicine.
Luncheon: To be served at the Ohio Union
Program: Morning Sessions:
Dr. Charles A. Doan will preside
Afternoon Sessions:
Dr. Philip S. Hench will preside
Guest Faculty: Darrell C. Crain, Jr., M. D., Assistant Professor of Clinical Medicine, Georgetown University, Washington, D. C.
Leon Goldman, M.D., Professor of Dermatology, University of Cincinnati, Cincinnati, Ohio
Dan M. Gordon, M.D. Assistant Professor of Ophthalmology, Cornell University, New York City
Philip S. Hench, M.D. Consultant, The Mayo Clinic, Rochester, Minn.
Bram Rose, M.D. Associate Professor of Medicine, McGill University, Montreal, Canada.
Lewis H. Sarett, Ph.D., Chief Chemist, Merck Sharp & Dohme Research Laboratories, Rahway, N. J.

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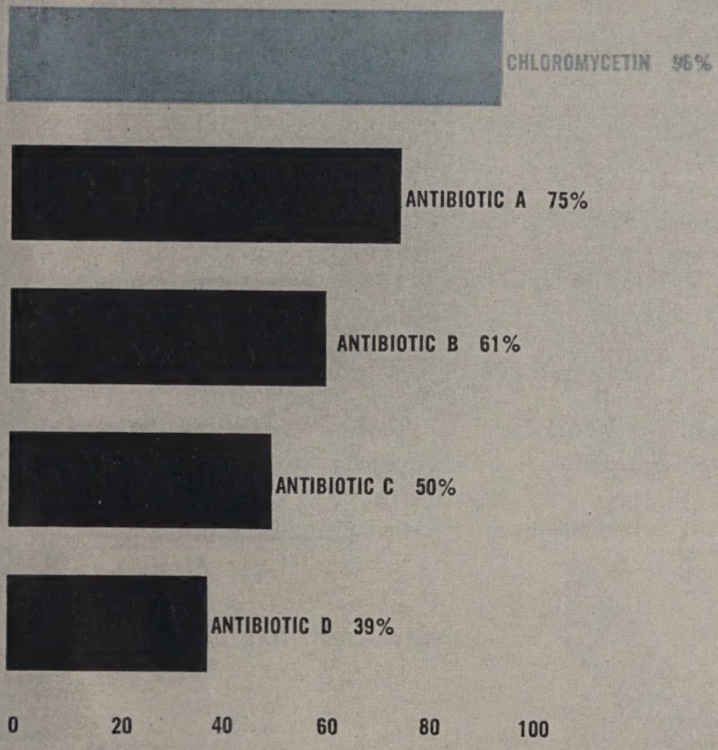

*Adapted from Godfrey & Smith.[1] Staphylococci studied were strains isolated from 28 patients in a general hospital.

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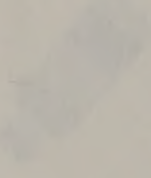

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